

## Letter of Medical Necessity

### Section 1 Patient Information

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Neck Circumference (Inches): \_\_\_\_\_

**To ensure prompt order processing and patient scheduling please complete *all* sections and fax this form along with *patient demographics, insurance card and exam notes* to 866-543-2519.**

### Section 2 Clinical Observations and Physical Findings

#### Symptoms and Medical History

##### (2A) Common Comorbidities:

- |   |   |  |                                       |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Impaired Cognition           | <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> Insomnia      | <input type="checkbox"/> Stroke       |

##### (2B) Other Comorbidities:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Loud, irregular snoring      | <input type="checkbox"/> Overwhelming episodes of sleep      | <input type="checkbox"/> Un-refreshing sleep   |
| <input type="checkbox"/> Observed apnea               | <input type="checkbox"/> Morning headache                    | <input type="checkbox"/> Obesity / weight gain |
| <input type="checkbox"/> COPD                         | <input type="checkbox"/> Restless, jerking legs during sleep | <input type="checkbox"/> Frequent awakenings   |
| <input type="checkbox"/> Loss of sex drive/motivation | <input type="checkbox"/> Awakening & gasping for breath      | <input type="checkbox"/> Cataplectic attacks   |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Enlarged tonsils                    | <input type="checkbox"/> Nasal Obstruction     |
| <input type="checkbox"/> Other: _____                 |  |  |

**\*\*Duration of Symptoms:** \_\_\_\_\_ Years \_\_\_\_\_ Months

### Section 3 Preliminary Diagnosis

- Obstructive Sleep Apnea -OSAS (327.23)     Narcolepsy (347.00)     Other:

### Section 4 Order Information

#### Complete Patient Care Pathway:

- Two Night Protocol with Specialist Consult:** Polysomnogram **AND** PAP Titration if clinically indicated. *A specialist consult referral will be generated if PSG is negative or after PAP Titration with appropriate sleep disorders treatment and follow up.*

#### Standard Order:

- Two Night Protocol without consult:** Polysomnogram **AND** PAP Titration if clinically indicated (If RDI is greater than 15 OR if RDI is between 5-15 with secondary symptoms as noted in **Section 2A.**)

#### Special Orders:

- |   |   |
|---|---|
| <input type="checkbox"/> Polysomnogram (Sleep study)    95810                           | <input type="checkbox"/> MWT (Wakefulness Test)    95805                            |
| <input type="checkbox"/> CPAP Titration    95811  | <input type="checkbox"/> MSLT (Narcolepsy Test)    95805                            |
| <input type="checkbox"/> Post Surgical Polysomnogram    95810                           | <input type="checkbox"/> Patient is on Oxygen @ _____ LPM                           |
| (Date of Surgery: _____)  | <input type="checkbox"/> Consultation with <i>Complete Health</i> Sleep Specialist. |
| <input type="checkbox"/> Special Instructions: _____                                    |   |
| <input type="checkbox"/> Does the patient have any special needs? If so, explain: _____ |   |

### Section 5 Medications

Please indicate below the medications that your patient may self administer at the sleep center:

\_\_\_\_\_

\_\_\_\_\_

**\*\*Note: No medication is kept at the sleep center\*\***

**PHYSICIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
 Print Physician Name: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Physician Phone: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_