PRESCRIPTION & STATEMENT OF MEDICAL NECESSITY

PATIENT INFORMATION

PATIENT NAME: DATE OF BIRTH: GENDER: ☐ MALE ☐ FEMALE

ADDRESS: HEIGHT: WEIGHT:

PHONE: MOBILE: EMAIL:

HOME SLEEP STUDY

☐ UNATTENDED HOME SLEEP TEST (HST)

PAP TREATMENT

☐ CPAP/APAP (E0601) ☐ BI-LEVEL (E0470) ☐ BI-LEVEL ST (E0471) ☐ ASV (E0471)

PAP PRESSURE SETTINGS:

☐ HEATED HUMIDIFICATION (E0562)
☐ ALL NECESSARY SUPPLIES (OR SELECTED SUPPLIES BELOW)

PAP SUPPLIES

☐ A7030 - MASK FULL FACE (1 X 90 DAYS)
☐ A7031 - CUSHION FULL FACE (3 X 90 DAYS)
☐ A7034 - MASK NASAL (1 X 90 DAYS)
☐ A7032 - CUSHION NASAL (6 X 90 DAYS)
☐ A7033 - PILLOW NASAL (6 X 90 DAYS)
☐ A7035 - HEADGEAR (1 X 180 DAYS)
☐ A4604 - TUBING HEATED (1 X 90 DAYS)
☐ A7038 - FILTER DISPOSABLE (6 X 90 DAYS)
☐ A7036 - CHIN STRAP (1 X 180 DAYS)
☐ A7046 - HUMIDIFIER CHAMBER (1 X 180 DAYS)
☐ A7037 - TUBING (1 X 90 DAYS)
☐ A7039 - FILTER REUSABLE (1 X 180 DAYS)
☐ OTHER:

DIAGNOSIS & ESS

☐ OBSTRUCTIVE SLEEP APNEA (G47.33)
☐ CENTRAL SLEEP APNEA (G47.31)
☐ OTHER:

EPWORTH SLEEPINESS SCALE (ESS) SCORE: _____

SIGNS & SYMPTOMS

☐ FATIGUE
☐ HYPERTENSION
☐ DROWSY DRIVING
☐ MORNING HEADACHES
☐ WITNESSED APNEA EVENTS
☐ IRRITABILITY/MOODINESS
☐ CHRONIC/HABITUAL SNORING
☐ PREVIOUSLY DIAGNOSED WITH OSA
☐ GASPING/CHOKING WHILE SLEEPING
☐ WITNESSED NOCTURNAL MOTOR ACTIVITY
☐ EXCESSIVE DAYTIME SLEEPINESS (ESS >= 11)
☐ OTHER:

LENGTH OF NEED

99 MONTHS (LIFETIME) OR:

PRESCRIBER'S INFORMATION

NAME: NPI:

ADDRESS:

PHONE: FAX:

SIGNATURE: **DATE:**

FAX COMPLETED PRESCRIPTIONS TO:

866-721-8481

SLEEPQUEST, INC. PHONE: 800-813-8358 REFERRALS@SLEEPQUEST.COM