

For faster processing, please complete all sections below and confirm the patient's current phone number.

PLEASE NOTE: Patients who cannot be removed from oxygen or CPAP to administer the AccuSom Home Sleep Test overnight should have an attended, in-lab sleep test. By sending this order to NovaSom, you are attesting that the patient can have a Home Sleep Test.

| PRESCRIBER INFORMATION | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------|
| Ordering Provider Name: | Phone #: | Fax #: | NPI (If this is provider's first order): |
| Office Contact Name: | | Phone# (If applicable, include extension #): | |
| PATIENT INFORMATION | | | |
| Last Name: | | First Name: | |
| Date of Birth (mm/dd/yyyy): | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Height: | Weight: |
| Address (Include apartment #. Unable to deliver to a P.O. Box): | | | |
| City: | | State: | Zip code: |
| Primary Phone (include area code): | Alternate Phone: | Language (if not English): | |
| PAYMENT/INSURANCE | | | |
| MUST CHECK ONE: | | | |
| Patient requests self-payment of \$297: <input type="checkbox"/> Charged in three (3) credit card installments of \$99 each. | | | |
| Patient requests insurance billing: <input type="checkbox"/> Attach copy of both front & back of insurance card and complete section below. | | | |
| Primary Plan: | Subscriber ID: | Policy Holder Name: | Policy Holder Birth Date: |
| Secondary Plan: | Subscriber ID: | Policy Holder Name: | Policy Holder Birth Date: |
| DIAGNOSIS/MEDICAL HISTORY/SYMPTOMS | | | |
| ICD-9 Code 327.23/ICD-10 Code G47.33 will be used for this Obstructive Sleep Apnea (OSA) test unless specified otherwise. (If other, specify): | | | |
| Medical Necessity of Home Sleep Testing: | | | |
| 1. Certain Payers require as many as four (4) symptoms but at least two (2). Please check <u>all</u> that apply. | | | |
| 2. Certain Payers require medical documentation/progress notes regarding testing for Sleep Apnea. Please attach these. | | | |
| <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | Habitual Snoring |
| <input type="checkbox"/> | Witnessed Apneic Events | <input type="checkbox"/> | Irritability/Moodiness |
| <input type="checkbox"/> | Witnessed Nocturnal Motor Activity | <input type="checkbox"/> | Morning Headaches |
| <input type="checkbox"/> | Fatigue | <input type="checkbox"/> | Daytime Sleepiness/Napping |
| <input type="checkbox"/> | Gasping/Choking | <input type="checkbox"/> | Drowsy Driving |
| <input type="checkbox"/> | | <input type="checkbox"/> | Previous Diagnosis of OSA |
| <input type="checkbox"/> | | <input type="checkbox"/> | Assessment of Efficacy of Surgery |
| <input type="checkbox"/> | | <input type="checkbox"/> | Assessment of Oral Appliance |
| <input type="checkbox"/> | | <input type="checkbox"/> | Assessment of Efficacy of Other Treatment |
| <input type="checkbox"/> | | <input type="checkbox"/> | Other (Specify): |
| Enter Epworth Sleepiness Scale Score (Range 0 – 24; ≥ 10 = High Risk): | | | |
| TEST TYPE - Home Sleep Test Only will be administered if nothing is checked below. | | | |
| <input type="checkbox"/> | Home Sleep Test Only (An up to three-night Sleep Test will be administered based upon ordering provider or payer) | | |
| <input type="checkbox"/> | Home Sleep Test including Titration Test; if patient is positive for Obstructive Sleep Apnea. | | |
| <input type="checkbox"/> | Titration Test Only | If Sleep Test was not done by NovaSom, supply date of last Sleep Test: | AHI: |
| DESIGNATED THERAPY/DURABLE MEDICAL EQUIPMENT (DME) PROVIDER AND RELEASE OF TEST RESULTS | | | |
| By entering contact information below, provider directs that any test results (whether positive or negative) additionally be sent to the therapy/DME provider for purposes of treatment of the patient. | | | |
| Therapy/DME Provider Name: | | Phone #: | Fax #: |

By signing below, I attest that: upon my examination of the patient, which included HEENT, Cardiovascular, Chest/Lung, Neurological and Vital Signs, there is a high probability of OSA. A Home Sleep Test is medically necessary and no co-morbid conditions are present that prevent the patient from home testing.

Provider's Original Signature (Stamped Signatures Not Accepted)

Date