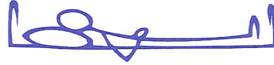


SLEEP STUDY SERVICE REQUEST

PATIENT NAME ____DATE OF BIRTH ______/______/_______

PATIENT PHONE: __________-__________-____________ SSN________-_________-________

PROVIDER: ____NPI#_____________________________

PROVIDER PHONE: __________-__________-____________ FAX: __________-__________-____________

INSURANCE COMPANY ____ PHONE _____-_____-________

MEMBER ID # ____GROUP # _________________________

TYPE OF SLEEP STUDY TO BE PERFORMED

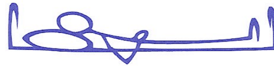
☐ Home Sleep Test (HST) (95806)
☐ Home Sleep Test (HST) (95806) - 2 night
☐ Home Sleep Test (HST) (95806) - 3 night

INDICATION FOR EVALUATION:

___ Excessive Daytime Sleepiness (EDS), Daytime Somnolence, Hypersomnia -ICD-10 Code G47.10
___ Obstructive Sleep Apnea (Previous Dx) -ICD-10 Code G47.33
___ Organic Sleep Apnea Unspecified (Documented Nervous/Respiratory Disorders) -ICD-10 Code G47.30
___ Insomnia with Sleep Apnea, Unspecified -ICD-10 Code G47.30
___ Other: ___________________________________ ICD-10 Code _______________________

PHYSICIAN SIGNATURE ____**DATE** ______/______/________

PHONE: 913-721-5511 DIRECT REFERRAL FAX NUMBER: 913-721-5402


PM SLEEP LAB

SLEEP STUDY SERVICE REQUEST

PATIENT NAME ____DATE OF BIRTH ______/______/_______

PATIENT PHONE: __________-__________-____________ SSN________-_________-________

PROVIDER: ____NPI#_____________________________

PROVIDER PHONE: __________-__________-____________ FAX: __________-__________-____________

INSURANCE COMPANY ____ PHONE _____-_____-________

MEMBER ID # ____GROUP # _________________________

TYPE OF SLEEP STUDY TO BE PERFORMED

☐ Home Sleep Test (HST) (95806)
☐ Home Sleep Test (HST) (95806) - 2 night
☐ Home Sleep Test (HST) (95806) - 3 night

INDICATION FOR EVALUATION:

___ Excessive Daytime Sleepiness (EDS), Daytime Somnolence, Hypersomnia -ICD-10 Code G47.10
___ Obstructive Sleep Apnea (Previous Dx) -ICD-10 Code G47.33
___ Organic Sleep Apnea Unspecified (Documented Nervous/Respiratory Disorders) -ICD-10 Code G47.30
___ Insomnia with Sleep Apnea, Unspecified -ICD-10 Code G47.30
___ Other: ___________________________________ ICD-10 Code _______________________

PHYSICIAN SIGNATURE ____**DATE** ______/______/________

PHONE: 913-721-5511 DIRECT REFERRAL FAX NUMBER: 913-721-5402