



Sleepwatchers, LLC

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SLEEP SERVICES ORDER

Patient: _____ DOB: _____ Mobile #: _____

1.	SERVICES	SYMPTOMS / DIAGNOSIS	OPTIONS
	<input type="checkbox"/> Medical Sleep Evaluation - 9920x	If a Sleep Evaluation is NOT requested, clinical records are REQUIRED to support medical necessity for Tests Ordered	<input type="checkbox"/> Face to Face <input type="checkbox"/> Virtual
	<input type="checkbox"/> Endoscopy - 31231	<input type="checkbox"/> Allergic Rhinitis	
	<input type="checkbox"/> At-Home Sleep Apnea Test - 95800 / 95806	<input type="checkbox"/> Snoring – R06.83	<input type="checkbox"/> No Preference <input type="checkbox"/> WatchPAT One (Disposable) <input type="checkbox"/> VirtuOx Dream (Reusable, 7 channels) <input type="checkbox"/> NightOwl (Reusable up to 10 nights) <input type="checkbox"/> SleepImage Ring (Reusable up to 3 nights)
	<input type="checkbox"/> NO significant comorbidities	<input type="checkbox"/> EDS Hypersomnia – G47.10	
		<input type="checkbox"/> Gasping, choking or pauses in breathing sleep	
		<input type="checkbox"/> Obesity – E66.9	
	<input type="checkbox"/> Baseline PSG - 95810 Split if indicated -95811	<input type="checkbox"/> Limb Movement Disorder – G47.61 <input type="checkbox"/> Seizure Disorder - specify <input type="checkbox"/> Sleep related movement disorder – G47.69 <input type="checkbox"/> Parasomnias Organic unspecified – G47.50 <input type="checkbox"/> REM behavior – G47.52	PSG Additional Parameters: <input type="checkbox"/> Nocturnal Oxygen: _____ LPM <input type="checkbox"/> Extended EEG <input type="checkbox"/> End Tidal CO2 Monitoring <input type="checkbox"/> Repeat Testing Until Behaviors are Documented
	<input type="checkbox"/> Titration PSG – 95811	<input type="checkbox"/> OSA - G47.33 <input type="checkbox"/> AHI < 15 with EDS <input type="checkbox"/> AHI > 15 <input type="checkbox"/> CSA – G47.31 <input type="checkbox"/> Central Sleep Apnea >50% of AHI	<input type="checkbox"/> CPAP <input type="checkbox"/> Bilevel <input type="checkbox"/> Servo Ventilation <input type="checkbox"/> Oral Appliance (Prior SS results Attached as Evidence)
	<input type="checkbox"/> MSLT - 95805 preceded by: PSG w/out CPAP - 95810 or PSG with CPAP - 95811	<input type="checkbox"/> EDS Hypersomnia – G47.10 <input type="checkbox"/> Hypnagogic or Hypnopompic Hallucinations <input type="checkbox"/> Sleep Paralysis – G47.53 <input type="checkbox"/> Cataplexy – G47.411	Performed after normal PSG to evaluate for Narcolepsy and/or Idiopathic Hypersomnolence Explain Symptoms:
	<input type="checkbox"/> Behavioral Sleep Medicine Evaluation & Treatment (CBTi)	<input type="checkbox"/> Circadian Rhythm Disorder – G47.29 <input type="checkbox"/> Insomnia – G47.00 <input type="checkbox"/> PAP Intolerance	Explain Symptoms:

2.	ORDERING PROVIDER	
NAME:	PHONE #:	
NPI #:	FAX #:	

PROVIDER SIGNATURE _____ DATE _____

PLEASE ATTACH ANY MEDICAL RECORDS THAT SUPPORT MEDICAL NECESSITY

FAX TO: (888) 608-0343