

Letter of Medical Necessity

Instructions: Complete this form in its entirety and along with the Patient's Information Sheet and Insurance Card, fax to (770) 777-1872.

Section 1 - Patient Information

Patient Name: _____	SSN: _____	DOB: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Height: _____	Weight: _____	B/P: _____

Section 2 - Clinical Observations and Physical Findings

Symptoms of Sleep Disorders:

- | | | |
|--|--|---|
| <input type="checkbox"/> Excessive daytime somnolence | <input type="checkbox"/> Un-refreshing sleep | <input type="checkbox"/> Loss of sex drive/motivation |
| <input type="checkbox"/> Loud, irregular snoring | <input type="checkbox"/> Frequent awakenings | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Observed apnea | <input type="checkbox"/> Cataplectic attacks | _____ |
| <input type="checkbox"/> Awakening from sleep gasping for breath | <input type="checkbox"/> Sleep paralysis | _____ |
| <input type="checkbox"/> Morning headache | <input type="checkbox"/> Overwhelming episodes of sleep | _____ |
| | <input type="checkbox"/> Restless, jerking legs during sleep | _____ |

Physical Findings and Medical History:

- | | | |
|--|--|--|
| <input type="checkbox"/> Nasal Obstruction (septal deviation or turbine hypertrophy) | <input type="checkbox"/> Large neck circumference | <input type="checkbox"/> Drug allergies: _____ |
| <input type="checkbox"/> Enlarged tonsils | <input type="checkbox"/> Obesity / weight gain | _____ |
| <input type="checkbox"/> Enlarged tongue | <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Posteriorly displaced tongue | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Retrognathia / micrognathia | <input type="checkbox"/> COPD | _____ |
| <input type="checkbox"/> Crowded oropharynx | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Crowded hypopharynx | <input type="checkbox"/> Epilepsy | _____ |
| | <input type="checkbox"/> Active infectious disease | _____ |

Section 3 - Preliminary Diagnosis

- Obstructive Sleep Apnea -OSAS (780.53) Narcolepsy (347) Other: _____

Section 4 - Study Order Information

- | | |
|---|--|
| <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"/> Two Night Protocol 95810 / 95811 | |
| <i>Polysomnogram, AND
CPAP Titration IF RDI > 15, OR
RDI is between 10 & 15 with appropriate secondary symptoms.</i> | |
| <input type="checkbox"/> Post Surgical Polysomnogram 95810 | <input type="checkbox"/> Patient is on Oxygen @ _____ LPM |
| (Date of Surgery: _____) | |
| <input type="checkbox"/> Special Instructions: _____ | |

PHYSICIAN SIGNATURE: _____	DATE: _____
Print Physician Name: _____	UPIN #: _____
Physician Phone: _____	Office Contact Name: _____