SLEEP APNEA OPTIONS

REFERRAL INSTRUCTIONS

Please send the following documents by fax or email when referring a new patient to our office (gotsleep@keepmesmiling.com or Fax 928-351-1621):

1. Last 3 PCP/PA SIGNED clinical notes detailing sleep.
2. CLEAR Copy of the most current insurance card
3. Prescription for HST (Home Sleep Study, if patient has not completed a sleep study within 1 year).
4. Letter of medical necessity for OAT (Oral Appliance Therapy, if sleep test and diagnosis completed).

If your patient has not completed a sleep study --- We work with a Third-Party Sleep Study facility that provides Home Sleep Studies with Telemedicine visits with a Board-Certified Sleep physician that can provide the Prescriptions & the Letter of Medical Necessity if necessary

We follow protocol for treating Sleep Apnea.

We will always send follow up letters so you can follow along with your patient's treatment.

We are participating providers with Medicare & Tricare. We work with and DIRECTLY bill all major medical insurance plans*

We always use the highest quality appliances. We are not a one size fits all office!

We are committed to continuing education for Sleep Apnea, Oral Appliance Therapy and are constantly challenging ourselves to read the latest studies.

We educate patients on the adjunct treatment options such as bed wedges, diet/weight loss, proper vitamin levels and proper sleep hygiene.

SLEEP APNEA OPTIONS

PATIENT NAME: _____ DATE: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____ Date of Birth: _____

INSURANCE NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Referral For:

___ Home Sleep Study/HST (CPT G0399 or 95800)

And/Or

___ Oral Appliance/OAT (CPT E0486)

DESCRIPTION OF SYMPTOMS

___ Excessive daytime sleepiness
___ Fatigue
___ SOB
___ Snoring
___ Restless legs
___ Nocturnal seizures
___ Witnessed apnea
___ Restless sleep
___ Weight Gain
___ Gasping (if living alone)
___ Diaphoresis
___ Epworth Score _____
___ Morning headaches
___ Enuresis
___ Other (explain) _____

MEDICAL HISTORY

___ CHF
___ Morbid Obesity
___ Stroke
___ Home O2 at ___ l/m
___ Diabetes
___ HTN
___ Seizures

ORDERING PHYSICIAN NAME: _____

SIGNATURE: _____ **DATE:** _____