Dr. ______________________________

UPIN# ____________ **NPI#:** ______________

REQUEST FOR SLEEP EVALUATION

Patient Name: ____ Gender: M / F

SS#: ____________________ D.O.B: ____________ Email Address: ________________________

Address: ____

City: ________________________ State: ___________ Zip Code: ______________________

Phone: Home ________________ Wireless ________________ Alt. Phone (Work) ________________

Name of Policy Holder: ______________________ SS.# __________________ DOB: ______________

Insurance Co.: ______________________ Group Name / No: ____________ Policy ID # ______________

Claims Address of Insurance Carrier: ____

City: _______________ State: _____ Zip Code: ________ Carrier Phone Number: __________________

EVALUATION ORDERED:

- ❑ 95810 Overnight Polysomnogram – Diagnostic Sleep Study on one night
  If diagnostic protocols indicate, follow with a CPAP titration on a subsequent night.
- ❑ 95811 Split - Overnight Diagnostic Sleep study followed by Therapeutic CPAP Titration if protocols are met.
- ❑ 95811 Overnight Therapeutic Titration using CPAP/Bi-level. Date of prior PSG or CPAP study ______________
- ❑ 95805 MSLT (Maintenance of Sleep Latency Test) or MWT (Maintenance of Wakefulness Test)

Symptoms: Snoring Witnessed apnea Headaches Fatigue Morning Headaches Nasal Obstruction Restless Sleep
Hypertension Excessive Daytime Sleepiness Anxiety Depression Insomnia Dry / Sore Throat

____

Provider Signature: ____ Date: ____________________

Contact Person at Practice for this referral: __________________________ Phone: ____________________

Physician's Office Instructions

Please complete and **fax this form to us with a copy of the patient's insurance card (front and back).**
Wellfirst Sleep Diagnostics will contact the patient and schedule the sleep study.
To contact a Wellfirst Sleep Diagnostics professional, phone: **1.877.USA.SLEEP**

Fax to: **972.692.5420**

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