BIOSERENITY
Smart Healthcare Solutions

HOME SLEEP TEST ORDER FORM

Prescription and Statement of Medical Necessity

Prescriber Information

Provider Name: Phone: Fax:

Primary Contact: NPI:

Patient Information

Patient Name: (Last) (First) (MI) Sex: M ☐ F ☐

Cell Phone: ____________________ Email: ______________________________________ DOB: ___________

Secondary Contact*: **Secondary Phone:** Height: Weight:

Sleep History & Physical: Must select all that apply

☐Disruptive snoring
☐Disturbed or restless sleep
☐Non-restorative sleep
☐Witnessed apnea event during sleep
☐Choking during sleep
☐Gasping during sleep
☐BMI >30
☐Frequent unexplained arousals from sleep
☐Excessive daytime sleepiness (EDS) as evidenced by an Epworth Sleepiness Scale > 10 (ESS)

Suspected Diagnosis (ICD-10):

☐Other _______________________________
☐Obstructive sleep apnea (G47.33)
☐Unspecified apnea (G47.30)
☐Hypersomnia (G47.10)
☐Assessment of Efficacy of Surgery

Does Patient have: ☐CHF? Severity: ☐Mild ☐Moderate ☐Severe
☐COPD? Severity ☐Mild ☐Moderate ☐Severe

Primary Plan:	Subscriber ID:	Policy Holder Name:	Policy Holder DOB:
Secondary Plan:	Subscriber ID:	Policy Holder Name:	Policy Holder DOB:

Diagnostic Service Ordered ☐Home Sleep Test (Type III) ☐Oral Appliance Efficacy

Durable Medical Equipment (DME) Provider & Release of Test Results: Provider has patient consent to direct positive test results to the DME provider below for purposes of treatment of the patient. Patient has been advised of their freedom of choice in selecting DME.

DME Name: Phone#: Fax #:

Physician Signature____ **Date**_________________________

I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

Fax Completed Prescription, Front & Back of the Patient Insurance Card & Medical Records to: (866) 216-5200

Customer Service - 877-753-3776 **www.bioserenity.com/easyorder**

* **Secondary** = Caregiver, Companion, or Legal Guardian