



ORDER FORM

NAME	PHYSICIAN
	PHONE
ADDRESS	FAX
PHONE	INSURANCE
MOBILE	
DOB	GENDER

Mercy Gilbert Medical Center's Sleep Center will obtain all prior authorizations for your convenience. Please fax this order form along with recent physician office notes and copy of your patient's insurance cards. We will notify you when your patient has been scheduled.

Fax # 602.798.0753

If you have any questions, please call 480.728.ZZZZ (9999).

INDICATIONS: *Check all that apply*

- | | |
|---|--|
| <input type="checkbox"/> Obstructive sleep apnea | <input type="checkbox"/> Routine PSG (95810) |
| <input type="checkbox"/> Snoring (786.09) | <input type="checkbox"/> CPAP Titration (previous study required or copy of study) (95811) |
| Fatigue, EDS (780.79) | <input type="checkbox"/> Split PSG with CPAP (if AHI > 15) (95811) |
| <input type="checkbox"/> Observed apnea, witnessed pauses in breathing (780.57) | <input type="checkbox"/> BIPAP Titration (95811) |
| <input type="checkbox"/> Nocturnal gasping for air | <input type="checkbox"/> PSG + MSLT (daytime study) (95810+95805) |
| <input type="checkbox"/> Coronary Artery Disease (414.01) | <input type="checkbox"/> MWT (daytime study) (95805) |
| <input type="checkbox"/> Chronic Heart Failure (428.42) | <input type="checkbox"/> Overnight Oximetry Screening (no charge) |
| <input type="checkbox"/> Hypertension (401.1) | <input type="checkbox"/> Additional instructions or requests: |
| <input type="checkbox"/> Obesity (278) | |
| <input type="checkbox"/> Excessive limb movements (780.10) | |
| <input type="checkbox"/> Insomnia (307.42) | |
| <input type="checkbox"/> Narcolepsy (347) | |

FOR SLEEP CENTER USE:

PT EMAIL

SS#

INSURANCE VERIFIED PRE-AUTHORIZATION INFORMATION