Home Sleep Apnea DropShip Test Medical Order Form

For Use in a DOT EXAM Setting

Snap Diagnostics, LLC
Singular Sleep, LLC

Patient Name:_____ DOB: _____

Social Security #: _____ Gender: _____ Phone: (___) _____

Email: _____ Height: _____ Weight: _____ Neck Size: _____

Address: _____ City: _____ State: ____ ZIP: _____

Alternate Contact: _____ Relationship: _____ Phone: (___) _____

Name of Insurance:_____ Policy #: _____ Group #: _____

Effective Date: _____ Name of insured if not patient: _____

Clinic Name: _____

Clinic Address: _____

Clinic City, State, Zip: _____

Clinic Phone: _____

Clinic Fax: _____

Comments: _____

Check any that apply

- ☐ Daytime fatigue
- ☐ Disruptive Snoring
- ☐ Excessive Daytime Sleepiness
- ☐ Hypertension / High Blood Pressure
- ☐ Witnessed Apneas (breathing pauses > 10 sec during sleep)
- ☐ Gasping / Choking
- ☐ Atrial Fibrillation (AFIB)
- ☐ Non restorative, disturbed or restless sleep

By signing below, I attest that based on my examination of the patient and his/her medical history, there is a high probability of Obstructive Sleep Apnea. An unattenede, type 3, Home Sleep Test with a minimum of 4 channels (airflow, respiratory effort, SpO2 saturatio nad heart rate), is medically necessary. No co-morbid conditions including, but not limited to moderate to severe COPD, CHF, OHS, neurodegenerative disorder or congnitive impairment are present that prevent the patient from home sleep testing.

Test Ordered: Type 3, unattended home sleep test for up to 3 nights or other _____
ICD-10 Code: G47.30 or CPT code: G0399 or 95806

PLEASE SIGN & DATE

_____ _____

Practitioner Signature **Date of Order**

FAX this page to Snap Diagnostics: 847.465.3401

REQUIRED DOCUMENTATION

Fax Required Documentation to: 847.465.3401

Sending the following information promotes efficient testing and maximizes the potential for insurance reimbursement.

a. Completed Home Sleep Apnea Test Medical Order Form located on opposite side of this page (Remember to check all indications that apply; sign & date where indicated).

b. Clinical note or DOT Form completed from the face-to-face encounter when the home sleep test was ordered.

HELPFUL HINTS

The following can help the sleep testing process go smoothly.

- The Ordering Medical Provider must complete the Sleep Test Medical Order form, which must be signed and dated.
- Marking all clinical indications that apply on Medical Order form is important if the patient wants to use their medical insurance.

WHAT HAPPENS AFTER YOUR REFERRAL

Sleep Test. Thank you for your referral. On receipt of the Required Documentation the Snap Diagnostics support team will contact your patient and complete the registration process. After our support team speaks with your patient, a recorder will be sent to their home to complete the sleep test.

Treatment. Per the protocol established by this Medical Order form, the preferred treatment provider, Singular Sleep, will contact patients that demonstrate sleep apnea to support the patient engaging a medical provider to discuss whether treatment is warranted.

SUPPORT

Written information and a short educational video is available online regarding an initiative to assess drivers at-risk for OSA during a DOT Exam.

https://www.snapdiagnostics.com/online-support-for-cdl/

For Sleep Testing Support call Snap Diagnostics: 800.762.7786

For Treatment Support call Singular Sleep: 844.757.9355