HOME SLEEP TEST REFERRAL/ORDER

DROPSHIP ONLY

Do not use if you dispensed a recorder from office

FAX form to: 847-465-3401

PATIENT NAME:		**DOB:**	**Preferred Phone: ( )**
Address:		City:	State: Zip:
Height:	Weight:	Neck Size:	Gender:

MEDICAL ORDER (This section outlined in **BOLD** may be replaced by an *approved* Electronic Medical Order)

Provider Name:	Address:
Name of Practice:	City:
Phone:	State: Zip:
Fax [to send patient test results]: ( )	E-mail:

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 unattended, type 3, Home Sleep Test with a minimum of 4 channels (airflow, respiratory effort, SpO2 saturation and heart rate), is medically necessary. No co-morbid conditions including, but not limited to, moderate to severe COPD, CHF, OHS, neurodegenerative disorder or cognitive 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: Default to G47.30 or Other code: _____
CPT code: G0399, 95806 or 95800

Provider Signature: _____ **Date of Order:** _____ PLEASE SIGN & DATE

Patient Clinical Indication and Medical History Details (check all that apply for the Patient)

- ☐ Witnessed apnea events during sleep greater than 10 seconds in duration
- ☐ Excessive Daytime Sleepiness
- ☐ Atrial Fibrillation (AFIB)
- ☐ Disruptive Snoring
- ☐ Hypertension / High Blood Pressure
- ☐ Non-restorative, disturbed or restless sleep
- ☐ Gasping / Choking
- ☐ Daytime Fatigue

Complete this section ONLY if Re-testing the Patient **Prior DX of Apnea?** ☐ No ☐ Yes (if yes, Test Date: _____)

A new sleep test is indicated due to (check all that apply):

☐ Weight gain or loss (> 10% or BMI > 5) ☐ Evaluate therapy effectiveness ☐ Evaluate need to continue therapy

Is the test: ☐ Pre or ☐ Post treatment? **Indicate Type of Treatment:** ☐ Surgery ☐ Oral Appliance ☐ PAP ☐ Other

Patient's Primary / Secondary Insurance	**Name of Insured (*if not patient*):**	
Primary Insurance Name:	Group #	ID #
Secondary Insurance Name:	Group #	ID #

Send Snap Test Report to DME? ☐ Yes DME Name: Fax: ( )

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FAX form to: 847-465-3401

Fax *Required Documentation* to 847.465.3401

Thank you for your referral. On receipt of the Required Documentation our support team will contact your patient and complete the testing process. *After our support team speaks with your patient, a Recorder will be sent to their home.*

REQUIRED DOCUMENTATION

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

a. Completed Sleep Test Referral Form (check all indications that apply and sign /date where indicated).

b. Clinical note from the face-to-face encounter when the sleep test was ordered.

HELPFUL HINTS

The following can help the sleep testing process to go smoothly.

- Do not use this Referral Form if you are dispensing a Snap Recorder to the patient from your office. Please use form QF-54809 when sending a patient home with a recorder from your office.
- The Ordering Medical Provider must complete the Medical Order section of the Sleep Test Referral form, which must be signed and dated by the Provider.

  The Medical Order section can be replaced with an approved Electronic Medical Order from the practice Electronic Health Record system. You must still complete all other sections of Sleep Test Referral form.

- Marking all clinical indications that apply on Referral form is important for insurance coverage.
- If you are re-testing patient it is important to indicate the purpose of the retest.
- If you would like the convenience of your preferred DME to receive the Snap Test report please complete that section on the Sleep Test Referral form.

DID YOU KNOW?

Most Electronic Health Records now allow patient referrals via **DIRECT MESSAGE.** SNAP is DIRECT MESSAGE compatible, because patient referrals are more efficient, there is a lower risk of errors, and your practice is credited for Meaningful Use of your EHR. There's no form to complete. SNAP returns the Test Report by Direct Message to your patient's medical record.

Learn more: https://snapdiagnostics.com/direct-message/