HOME SLEEP TEST MEDICAL ORDER

Direct Ship Form

For use with Direct Mail-Order Service

Fax: (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)
- ☐ 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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Submitting Orders

1. **Complete the Order Form**. Please check all indications that apply and sign/date where indicated.
2. **Provide Clinical Documentation**. Include the clinical note from the patient encounter in which the sleep test was ordered, as well as relevant history and physical information.
3. **Submit the Form and Documentation to Snap**. Orders may be submitted:
   - By fax to **(847) 465-3401**, or alternate fax **(888) 234-4541**
   - Online at **https://snapdiagnostics.org**

     To upload files using a smartphone or tablet, scan this QR code with your phone's camera
   - Directly from your electronic health record system (EHR)

Electronic Orders

The *Medical Order* section of the form can be replaced with an approved electronic medical order from your EHR. You must still complete all other sections of the form, or provide equivalent documentation.

You can also submit your order by **Direct message** from your electronic health records to Snap Diagnostics' Direct address:

Lab@SleepTest.Direct.kno2fy.com

For providers using electronic health records, Direct messaging ensures efficient exchange of health information, reduces errors, and improves care coordination.

To learn more, visit https://snapdiagnostics.com/direct-message

Order Status

Thank you for your referral. Upon receipt of the order, we will reach out to your patient to coordinate delivery of our home sleep test. Once ready, the sleep test results will be faxed to your office. In addition, you may track your order and access results through our secure online portal at https://snapdiagnostics.org

To inquire about the status of a test, contact **support@snapdiagnostics.com** or call **(800) 762-7786.**