

Provider Order Form for Home Sleep Test

Patient Contact Information

Name:	D.O.B:	
Address:		
City:	State:	Zip:
Phone:	Email:	
Sex:	Height:	Weight:
Insurance: <small>(for internal use only)</small>	Insurance Verification and Patient Co-Pay are Not Required Select " <u>Easy Breathe – Bill to Equipment Supplier</u> " as Insurance	

Provider Contact Information

Name:	Email	
Address:		
City:	State:	Zip:
Phone:	Fax:	

National Provider Identification ("NPI") Number

Diagnosis Code (Select One) and Procedure ("On Room Air" unless noted)

- | | |
|--|---|
| <input type="checkbox"/> 327.23 Obstructive Sleep Apnea | <input type="checkbox"/> 780.57 Other & Unspecified Sleep Apnea |
| <input type="checkbox"/> 780.53 Hypersomnia w/ Sleep Apnea | <input type="checkbox"/> Other ICD-9 _____ |

Procedure: Type III Unattended Home Sleep Test Portable Recorder: records airflow, respiratory effort, O2 saturation and pulse to detect apnea and hypopnea events, snoring, etc.

"On Room Air" unless the following is checked: Test on current nocturnal O2 prescription. Patient must already be on O2. We cannot furnish O2.

Other Comments:

I, the undersigned, certify that by signing below I am ordering a home sleep test for the patient listed above.

Provider Signature: _____ Date: _____

(Must be one of the following: Doctor of Osteopathy, Medical Doctor, Physician's Assistant or Nurse Practitioner)

Please sign and return via fax to (877) 883-9709 or via email to info@easybreathe.com