



HOME SLEEP TEST ORDER FORM
Prescription and Statement of Medical Necessity

PRESCRIBER INFORMATION
PATIENT INFORMATION
SLEEP HISTORY & PHYSICAL
SUSPECTED DIAGNOSIS (ICD-10):
DOES PATIENT HAVE:
INSURANCE/PAYMENT INFORMATION
DIAGNOSTIC SERVICE ORDERED:
PHYSICIAN SIGNATURE:
POSITIVE AIRWAY PRESSURE (PAP) THERAPY, DURABLE MEDICAL EQUIPMENT (DME) PROVIDER & RELEASE OF TEST RESULTS:

FAX COMPLETED PRESCRIPTION, FRONT & BACK OF THE PATIENT INSURANCE CARD
& RECENT CLINICAL NOTES TO (866) 216-5200 | FOR CUSTOMER SERVICE, CALL (877) 753-3776