REACTDx

HOME SLEEP TEST ORDER FORM

Prescription and Statement of Medical Necessity

PRESCRIBER INFORMATION **SITE NAME/ID:**

Provider Name: Phone: Fax:

Primary Contact: NPI:

PATIENT INFORMATION

Patient Name: (Last) (First): (MI):

Sex: ☐ M ☐ F DOB: Height (ft, in): Weight (lbs):

Address (Include Apartment Number. Unable to deliver to a PO Box):

City: State: Zip Code:

Cell Phone: Email:

Secondary Contact*: Secondary Phone:

SLEEP HISTORY & PHYSICAL *(Must select all that apply.)*

- ☐ Disruptive snoring
- ☐ Non-restorative sleep
- ☐ Choking during sleep
- ☐ BMI > 30
- ☐ Disturbed or restless sleep
- ☐ Witnessed apnea event during sleep
- ☐ Gasping during sleep
- ☐ Frequent unexplained arousals from sleep
- ☐ Excessive daytime sleepiness (EDS) as by an Epworth Sleepiness Scale > 10 (ESS)

SUSPECTED DIAGNOSIS (ICD-10):

- ☐ Obstructive Sleep Apnea (G47.33)
- ☐ Hypersomnia (G47.10)
- ☐ Other _____
- ☐ Unspecified apnea (G47.30)
- ☐ Assessment of Efficacy of Surgery

DOES PATIENT HAVE:

- ☐ CHF? Severity: ☐ Mild ☐ Moderate ☐ Severe
- ☐ COPD? Severity: ☐ Mild ☐ Moderate ☐ Severe

INSURANCE/PAYMENT INFORMATION ☐ Patient requests self-payment of $250 -- OR -- Provide insurance Information below.

Primary Plan: Subscriber ID: Policy Holder Name: Policy Holder DOB:

Secondary Plan: Subscriber ID: Policy Holder Name: Policy Holder DOB:

DIAGNOSTIC SERVICE ORDERED: ☐ Home Sleep Test (Type III) ☐ Oral Appliance Efficacy

PHYSICIAN SIGNATURE: _____ **DATE:** _____

I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition. So that my patient may receive in-network services covered by my patient's health insurance plan, I authorize the ReactDx company that received an order from me to forward my order to an affiliated ReactDx company that is an in-network provider under my patient's health insurance plan.

POSITIVE AIRWAY PRESSURE (PAP) THERAPY, DURABLE MEDICAL EQUIPMENT (DME) PROVIDER & RELEASE OF TEST RESULTS:

Provider has patient consent to direct positive test results to the DME provider below for purposes of treatment of the patient using a Luna G3 PAP. Patient has been advised of their freedom of choice selecting both PAP and DME.

DME Name: _____ Phone: _____ Fax: _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

I certify that, based on a positive HST test, treatment is medically indicated and is reasonable and necessary with the standards of medical practice and treatment of this patient's condition.

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

BioSerenity USA, Inc. dba ReactDx
Watermark Medical, Inc. dba ReactDx

Clear Form

*Secondary Contact = Caregiver, Companion, or Legal Guardian