Watch-PAT®
Home Sleep Study
Prescription / Order

Certificate of Medical Necessity

Patient (Last, First, MI) _____ **Today's Date** _____

Insurance Carrier/ ID# _____ **Date of Birth (mm/dd/yyyy)** _____

Patient Address _____ **Home Phone** _____ ( )*

_____ **Work Phone** _____ ( )*

_____ **Cell Phone** _____ ( )*

Email _____ (*indicated preferred number to contact)

Height _____ **Weight** _____ **(or BMI)** _____ **Epworth Score** _____ **Male** ☐ **Female** ☐

☐ **HOME SLEEP STUDY 1**	☐ **HOME SLEEP STUDY 2**	☐ **HOME SLEEP STUDY 3**	☐ **HOME SLEEP STUDY 4**
w/ Certified Sleep Physician Interpretation **"HIGH PROBABILITY OF OSA"** (ESS≥10, BMI≥30 & symptoms (√ below))	w/ Certified Sleep Physician Interpretation **FOLLOW UP** Indication(Circle): CPAP* OAT* Surgery Weight Loss *Perform Study W☐ W/O☐ Therapy	w/ Certified Sleep Physician Interpretation **OSA Suspected** Patient Pay (Non-conforming Sleep Parameters)	Comprehensive Sleep Study Report **w/o** Interpretation **OSA Screening** Patient Pay Quantification by Qualified physician for snoring/treatment

Does patient have a permanent pacemaker? ☐ **Yes** ☐ **No** **Is the patient on Oxygen?** ☐ **Yes**** ☐ **No**

****If Yes - is on room air testing approved?** ☐ **Yes** ☐ **No**

Sleep History / Conditions / Symptoms (check all applicable - at least one)

√		√		√		√	
☐	**Loud, Disruptive Snoring**	☐	**Ischemic Heart Disease**	☐	**Impaired Cognition**	☐	**Diabetes**
☐	**Witnessed Apnea > 10 sec. by** _____	☐	**Chronic Fatigue**	☐	**Morning Headaches**	☐	**Elongated Soft Palate**
☐	**Gasping or Snorting (During Sleep or Upon Waking Up)**	☐	**Hypertension**	☐	**Insomnia**	☐	**Nasal Obstruction**
☐	**Excessive Daytime Sleepiness**	☐	**History of Stroke**	☐	**Obesity**	☐	**Swollen Turbinates**
☐	**Please list any medications taken:**						

Primary Diagnostic ICD-9 Code (check only one)

☐	**327.23 Obstructive Sleep Apnea (Adult & Pediatric)**	☐	**780.57 Unspecified Sleep Apnea**	☐	**327.51 Periodic Limb Movement Disorder**
☐	**327.21 Primary Central Sleep Apnea**	☐	**347.00 Narcolepsy without Cataplexy**	☐	**443.0 Raynaud's Disease**
☐	**307.46 Sleepwalking, Sleep Terrors**	☐	**347.01 Narcolepsy with Cataplexy**	☐	**496.0 COPD**

PATIENT'S INSURANCE INFORMATION: ***Attach copy of front and back of insurance card*** (as indicated)

_____ _____ _____

Physician Signature **Date** **Physician Name (printed)**

☑ By signing below, I acknowledge that I have received and read 1st Line Medical, Inc.'s Policy Statement and give permission to 1st Line Medical, Inc. to bill my Insurance company.

_____ _____

Patient Signature Date

Submit via Fax #: *800-918-7860*

Phone Number: 866-720-8080