WHY DME PROVIDERS CHOOSE BREATHE

HOME SLEEP STUDIES ARE FAST, SIMPLE & AFFORDABLE!

FAST Turnaround time.

SIMPLE Breathe ships the Home Sleep Study device directly to the patients home.

AFFORDABLE A Home Sleep Study test costs less than an in lab study.

THERAPISTS Sleep studies are scored by our in house respiratory therapists.

PHYSICIANS Sleep studies are interpreted by our sleep boarded physicians.

ONLINE PORTAL Breathe provides an online portal that tracks patients testing status.

IN-NETWORK INSURANCE PROVIDERS

Breathe is in network with over 350 insurance providers!

- Aetna
- Blue Cross Blue Shield
- Cigna
- Humana
- Medicare
- Tricare

HOME SLEEP TEST (HST) ORDER FORM

BREATHE

OVERNIGHT OXIMETRY - HOME SLEEP TESTING - CAPNOGRAPHY
WWW.FASTOXIMETRY.COM
SUBMIT VIA FAX TO: 877-832-0388
CUSTOMER SUPPORT: 816-960-3510

PATIENT INFORMATION

NAME______________________ GENDER ○ M ○ F BIRTHDAY(m/d/y) ____________ SS# ______________

ADDRESS ______________________ CITY______________________ STATE ________ ZIP ________

HOME PHONE ____________ WORK PHONE ____________ CELL PHONE ____________ EMAIL______________

EMERGENCY CONTACT

NAME______________________ CELL PHONE ____________ HOME PHONE ____________

INSURANCE *Please send copy of chart notes, insurance card and/or face sheet to Breathe. MEDICAID not accepted at this time.*

○ CHECK HERE IF SELF PAY

○ HAS THE PATIENT HAD A SLEEP STUDY BEFORE? ○ Y ○ N IF YES, HOW LONG AGO____________

PAYOR NAME (PRIMARY)______________________ ID# ______________________ GROUP# ______________

PAYOR NAME (SECONDARY)______________________ ID# ______________________ GROUP# ______________

DIAGNOSIS

Obstructive Sleep Apnea (ICD10: G47.33) will be used unless otherwise specified below.

ADDITIONAL / OTHER DIAGNOSIS: ICD10: __________ DESCRIPTION: ______________________________

NOTE: Many payors require OSA dx for coverage

TEST PROCEDURE

Home Sleep Test: *Type III Study, On Room Air to evaluate for Obstructive Sleep Apnea / Sleep Disordered Breathing. Check all that apply:*

○ Patient currently on nocturnal oxygen?**	○ Test to evaluate dental appliance
○ Patient currently on PAP** (CPAP, BiPAP, other)	○ Test is to evaluate post-surgery OSA
○ Yes ○ No ** Can 02 / PAP therapy be removed during the test?	○ Test to evaluate OSA following weight loss
** HST device manufacturers do not recommend performing test on O2 or PAP	○ Other: ______________

SLEEP HISTORY & PHYSICAL EXAM *(Fill in the blanks and check all symptoms that apply)*

Height________inches Weight________lbs BMI________ Neck Size________inches Sleep Epworth Score ______(0-24)

MEDICAL HISTORY *(Check all that apply -None checked denotes none present)*

		COMORBID CONDITIONS	OTHER SUSPECTED SLEEP DISORDERS
○ Observed Apneas	○ Choking/Gasping during sleep	○ COPD - Mod to Severe	○ Narcolepsy
○ Daytime Sleepiness Epworth Score______	○ Inappropriate napping	○ CHF (NYHA class III or IV)	○ Nocturnal seizures
○ Habitual Disruptive Snoring	○ Morning Headaches	○ Recent stroke or TIA (last 30-days)	○ Central Sleep Apnea
○ Non-Restorative Sleep	○ Craniofacial or upper airway soft tissue abnormalities	○ Neuro-degenerative disorder /weakness	○ Hyper or Parasomnias
○ Obesity (BMI >30)	○ Large Neck (>17" M. 16" F)	○ Significant, persistent cardiac arrhythmia	○ Restless Leg (PLMD)
○ Hypertension, Uncontrolled		○ Obesity hypoventilation syndrome	○ ______________
		○ Chronic Opiate Narcotic use	

PREFERRED DME AND RELEASE OF TEST RESULTS

By entering the below DME, provider directs that any test results will be additionally sent to the DME for purposes of treatment of the patient.

DME SUPPLIER______________________ LOCATION ID# ____________ PHONE ______________ FAX ______________

ORDERING PHYSICIAN INFO AND SIGNATURE

NPI:____ ____ ____ ____ ____ ____ ____ ____ ____ ____ *(PHYSICIAN'S INDIVIDUAL NPI REQUIRED!!! Physician PA/NP only)*

LAST NAME______________________ FIRST NAME ______________________

ADDRESS ______________________ CITY______________________ STATE ________ ZIP ________

FAX______________________ PHONE ______________________

*I the undersigned, authorize Breathe to perform a 2 night home sleep apnea test on above patient. I certify that I am the physician identified on this form. I certify that the medical necessity information is true accurate and complete to the best of my knowledge. I certify I am qualified, under CMS guidelines to sign and prescribe medical equipment and supplies. The patient's medical record contains supporting documentation and will be provided to Breathe upon request. I understand any falsification, omission, or concealment of material fact in any section may subject me to civil or criminal liability. A copy of this order will be retained as part of the medical record.

SIGN HERE ______________________________________ DATE ______________

STAMPED DATES AND SIGNATURES ARE NOT VALID, MUST BE SIGNED BY PHYSICIAN/PA/NP ONLY.
FAX CHART NOTES & INSURANCE CARD TO BREATHE (877) 832-0388. FOR QUESTIONS CALL (816) 960-3510.