Pivotal Health

HOME SLEEP TEST ORDER FORM
Prescription and Statement of Medical Necessity

PRESCRIBER INFORMATION

DME COMPANY:

SITE NAME/ID:

Provider Name: Phone: Fax:

Primary Contact NPI: Email:

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 (Caregiver, Companion or Legal Guardian): Secondary Phone:

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

☐ Disruptive Snoring ☐ Disturbed or Restless Sleep ☐ Witnessed apnea event during sleep

☐ Non-restorative sleep ☐ BMI>30 ☐ Frequent unexplained arousals from sleep

☐ Choking during sleep ☐ Gasping during sleep ☐ Excessive daytime sleepiness (EDS) as by an Epworth Sleepiness Scale > 10 (ESS)

SUSPECTED DIAGNOSIS (ICD-10)

☐ Obstructive Sleep Apnea (G47.33) ☐ Unspecified apnea (G47.30)

☐ Hypersomnia (G47.10 ☐ Assessment of Efficacy of Surgery

☐ Other

DOES PATIENT HAVE ☐ CHF? **SEVERITY:** ☐ Mild ☐ Moderate ☐ Severe

☐ COPD? **SEVERITY:** ☐ Mild ☐ Moderate ☐ Severe

INSURANCE/PAYMENT INFORMATION ☐ **Patient requests HST 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:

ADDITIONAL SERVICE (If insurance allows):

☐ **THERAPY & REMOTE PATIENT MONITORING -REFERRAL TO INTEGRATED SLEEP CARE (ISC) CLINIC**
Forward HST test results to ISC for patient follow-up including therapy, if indicated and remote patient monitoring. Provider has patient consent to direct positive results to ISC for purposes of treatment. Visit with Sleep Health Provider, Provider Orders Therapy, Orders RPM and follow up visits.

DURABLE MEDICAL EQUIPMENT (DME) PROVIDER & RELEASE OF TEST RESULTS:
Provider certifies that it has obtained patient authorization as required under applicable law, including HIPAA, to direct the positive test results to the DME supplier below for purposes of treatment of the patient and that the patient has been advised of their freedom of choice selecting the DME supplier.

DME of Choice (if applicable): _____ Phone: _____ Fax: _____

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 Pivotal Health company that received an order from me to forward my order to an affiliated Pivotal Health company that is an in-network provider under my patient's health insurance plan.

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