GBMC HEALTHCARE

The Sleep Center at GBMC
Greater Baltimore Medical Center
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GBMC SLEEP CENTER STANDARD REQUEST MEDICAL NECESSITY FORM

Patient Name: ____ **D.O.B.** ______________________

Phone Number(s): ______________________________ **Referring Physician:** ________________

Office Phone: _______________________ **Office Fax:** _________________________

PLEASE ATTACH DEMOGRAPHICS AND INSURANCE CARDS/REFERRAL IF NEEDED

Indication(s):

☐ Sleep Apnea (G47.33) ☐ Fatigue ☐ Snoring ☐ Insomnia ☐ Obesity ☐ Hypersomnia
☐ Periodic Limb Movement/Restless Legs ☐ Pre-op evaluation for Bariatric Surgery ☐ Pulmonary HTN

☐ Other Indication____

Pre-Sleep Study Consultation Requests:

☐ **CONSULTATION WITH SLEEP MEDICINE SPECIALIST (*Prior* to the sleep study)**
Sleep Medicine physician will conduct complete care (order sleep study, necessary therapy and follow up)

Sleep Study Requests: **Please specify type of study requested AND a followup option below:**

☐ **Diagnostic Nocturnal Polysomnogram** **(Split if calculated AHI >/= 40) (*CPT 95810)***

☐ **Combined Diagnostic and Therapeutic NPSG (SPLIT- NIGHT): (*Attended overnight PSG for approximately 2 hours, followed by CPAP titration study If the Apnea Hypopnea-Index (AHI) is above 20/hour within the first 2 hours of testing*) (*CPT 95811)***

☐ **Continuous Positive Airway Pressure (CPAP) Titration Study (*CPT 95811*)**

☐ **OTHER:** ☐ **BIPAP titration (CPT 95811)** ☐ **ASV titration** ☐ **MSLT** ☐ **MWT** ☐ **CPAP/ASV Combined Study**
Note: CPT Code for MSLT/MWT is 95805

Post Sleep Study Followup Options: (Please choose one)

☐ **Post-sleep study consultation with a Sleep Specialist**. (The sleep specialist will handle ordering equipment, therapy and follow up)
☐ **Order CPAP titration study and/or Initiate CPAP therapy**, as recommended by the interpreting physician. *(Equipment will be ordered upon prescription by the ordering physician and follow up care will be provided by the ordering physician without a sleep specialist consultation)*.

I authorize the Sleep Center to order CPAP/BIPAP test or CPAP /BiPAP therapy for this patient if interpreting physician recommends

For MEDICARE patients MUST COMPLETE THE FOLLOWING:

Symptoms: Circle Yes or No	Physical Examination: Attach detailed notes	General Exam:
Excessive daytime somnolence Y N	Neurological: ☐ Normal Sleepy/Lethargic Y N	Height:
Witness apneas Y N	Focal Findings:	HR:
Napping/sleeping during day Y N	Cardiovascular: Rhythm Normal Y N	BP:
Falling asleep during driving Y N	Pulmonary exam Normal Y N	Weight:
Functional Limitations/Fall Risk? Y N	Nose, Throat and Pharynx: Normal Y N Mallampati Score(optional)	Temp:
Witnessed Apneas Y N	Abnormal (describe)	RR:
Other:		BMI:

Special Instructions:____

Signature: ____________________________ **Printed Name:** _____________________ **Date**: ___________