NIGHT HAWK
SLEEP SYSTEMS INC.

Please submit order via fax to 1-877-416-2580
For assistance contact us at 1-877-622-2022

TEST TYPE		
Home Sleep Test Only will be administered if nothing is checked below.		
☐	Home Sleep Test Only (An up to three-night Sleep Test will be administered based upon ordering provider or payer)	
☐	Polysomnogram including Titration Test; if patient is positive for Obstructive Sleep Apnea.	
☐	Titration Test Only	If Sleep Test **was not** done by Night Hawk, supply date of last Sleep Test: AHI:
☐	Home Sleep Test with Home CPAP-Auto titration if patient is positive for sleep apnea	

DURABLE MEDICAL EQUIPMENT (DME) PROVIDER RELEASE OF TEST RESULTS		
Therapy/DME Provider Name:	Phone #:	Fax #:

PRESCRIBER INFORMATION			
Ordering Provider Name:	Phone #:	Fax #:	NPI (If this is provider's first order):
Office Contact Name:		Phone# (If applicable, include extension #):	

PATIENT INFORMATION			
Last Name:		First Name:	
Date of Birth (mm/dd/yyyy):	Gender: ☐ Male ☐ Female	Height:	Weight:
Address **(Include apartment #. Unable to deliver to a P.O. Box):**			
City		State	Zip Code
Primary Phone (include area code):	Alternate Phone:		Language (if not English):

INSURANCE INFORMATION			
Please attach a copy of patient's insurance card; include BOTH front and back of the card. Also complete section below.			
Primary Plan:	Subscriber ID:	Policy Holder Name:	Policy Holder Birth Date:
Secondary Plan:	Subscriber ID:	Policy Holder Name:	Policy Holder Birth Date:

DIAGNOSIS/MEDICAL HISTORY/SYMPTOMS					
Diagnosis code G47.33 Obstructive Sleep Apnea (OSA) will be used for this test unless otherwise specified. (If other, specify):					
Medical Necessity of Home Sleep Testing: ***Certain Payers require as many as four (4) symptoms but at least two (2). Please check all that apply.***					
☐	Assessment of Efficacy of Other Treatment	☐	Fatigue	☐	Unexplained Hypertension
☐	Assessment of Oral Appliance	☐	Gasping/Choking	☐	Witnessed Apneic Events
☐	Daytime Sleepiness/Napping During Day	☐	Habitual Snoring	☐	Witnessed Nocturnal Motor Activity/Flailing
☐	Efficacy of Surgery/Previous Diagnosis of OSA	☐	Irritability/Moodiness	☐	Other (Specify):
☐	Falling Asleep at Work or While Driving	☐	Morning Headaches	☐	Other (Specify):
Enter Epworth Sleepiness Scale Score (Range 0 – 24; ≥ 10 = High Risk):					

Upon submission of this sleep testing prescritption, please provide clinical notes from the appointment in which the medical necessity of a sleep study was determined.

Providers Signature _____ Date _____