

# HOME SLEEP STUDIES FAX FORM

| PRESCRIBER INFORMATION       |   | PATIENT INFORMATION     |     |
|------------------------------|---|-------------------------|-----|
| PHYSICIAN NAME               | PROVIDER ID/TAX ID (if out of state must have tax ID) | PATIENT NAME            |     |
| CONTACT PERSON/PRACTICE NAME |   | PATIENT'S BCBSNC ID     |     |
| PRACTICE PHONE               | PRACTICE FAX  | PATIENT'S DATE OF BIRTH |     |
| PRACTICE ADDRESS             | CITY  | STATE                   | ZIP |

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

1. Select CPT code: \_\_\_ 95800 \_\_\_ 95801 \_\_\_ 95803 \_\_\_ 95806 \_\_\_ G0398 \_\_\_ G0399 \_\_\_ G0400
2. For a diagnosis of obstructive sleep apnea (OSA) indicate which symptoms are present
  - Habitual Snoring .....  Yes  No
  - Observed Apneas .....  Yes  No
  - Excessive daytime sleepiness.....  Yes  No
  - Body mass index (BMI) greater than 35 .....  Yes  No
3. Does the member have any of the following:
  - Central sleep apnea .....  Yes  No
  - Congestive heart failure (CHF) .....  Yes  No
  - Chronic pulmonary disease (for example, asthma, COPD, sarcoidosis, etc .....  Yes  No
  - Obesity hypoventilation syndrome .....  Yes  No
  - Narcolepsy .....  Yes  No
  - Periodic limb movements in sleep .....  Yes  No
  - Restless leg Syndrome .....  Yes  No
  - Complex sleep apnea .....  Yes  No
4. Indicate which of the following applies to the interpreting and billing physician:
  - \_\_\_ Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM), **OR**
  - \_\_\_ Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS), **OR**
  - \_\_\_ Completed residency or fellowship training by an ABMS member board and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible, **OR**
  - \_\_\_ Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission (Formerly the Joint Commission on Accreditation of Healthcare).
  - \_\_\_ None of the above

Effective: 1/1/11

**PHYSICIAN ATTESTATION:** By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

**Please certify the following by signing and dating below:**

\*Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

(\*Original Physician signature required. Stamped signatures not acceptable)

**For BCBSNC and NC State Health Plan members, fax form to 1-800-228--0838**

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