# HOME SLEEP STUDIES FAX FORM

<table>
<thead>
<tr>
<th>PRESCRIBER INFORMATION</th>
<th>PATIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHYSICIAN NAME</td>
<td>PROVIDER ID/TAX ID  (if out of state must have tax ID)</td>
</tr>
<tr>
<td>CONTACT PERSON/PRACTICE NAME</td>
<td>PATIENT'S BCBSNC ID</td>
</tr>
<tr>
<td>PRACTICE PHONE</td>
<td>PRACTICE FAX</td>
</tr>
<tr>
<td>PRACTICE ADDRESS</td>
<td>CITY</td>
</tr>
</tbody>
</table>

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

Select CPT code: ___95800 ___95801 ___95803 ___95806 ___G0398 ___G0399 ___G0400

Date member will be issued equipment: ____________________________

1. Is member younger than 18 years of age? ................................................................. □ Yes □ No

2. The patient is at high risk of obstructive sleep apnea as evidenced by (check all that apply):
   - □ Excessive daytime sleepiness (as evidence by a pre-treatment Epworth score of greater than 10)
   - □ Habitual Snoring
   - □ Body mass index (BMI) greater than 35
   - □ Observed apneas

3. Does the member have any of the following conditions (check all that apply)?
   - □ Central sleep apnea
   - □ Chronic pulmonary disease
   - □ Congestive heart failure
   - □ Obesity hypoventilation syndrome
   - □ Narcolepsy
   - □ Injurious or potentially injurious parasomnias

4. The scheduled home study will record 4 channels, including oxygen saturation, respiratory movement, Airflow, and EKG or heart rate?................................................................. ........... □ Yes □ No

5. Is the patient scheduled for bariatric surgery and has no evidence by history or physical examination of a health condition that might alter ventilation or require alternative treatment?............... □ Yes □ No

6. The **repeat** 4 channel home sleep study is for:
   - □ To assess efficacy of surgery or oral appliance/device?
   - □ To re-evaluate OSA and continued need for CPAP?

Continue on page 2
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 members, fax form to 1-800-672-6587
For NC State Health Plan members, fax form to 1-866-225-5258
For APPEALS for BCBSNC Members, fax form to 919-765-4409
For APPEALS for NC State Health Plan Members, fax form to 919-765-2322

Effective: 09/14/2017