Own Sleep Medicine
P: 833-777-1069 | F: 833-777-2969
www.ownsleepmed.com

PROVIDER ORDER FORM

PATIENT INFORMATION:

Name: _____ | M ☐ F ☐ | DOB: ____/____/_____

Patient Phone: _____ | Email: _____

DIAGNOSIS:

- ☐ Obstructive Sleep Apnea (G47.33)
- ☐ Sleep Apnea / Witnessed Apnea - Unspecified Type (G47.30)
- ☐ Excessive Daytime Sleepiness / Fatigue / Hypersomnia (G47.10)
- ☐ Snoring (R06.83)
- ☐ Other: _____

ORDERS:

- ☐ Home Sleep Test | CPT 95806 / G0399
- ☐ Telemedicine Consultation with Sleep Physician | CPT 99201-99204

*****ALL ORDERS MUST INCLUDE THE MOST RECENT APPLICABLE OFFICE NOTE WITH PATIENT DEMOGRAPHICS & INSURANCE CARD(S)*****

Special Considerations:

_____

_____

PROVIDER:

Provider Name: _____ NPI: _____

Provider Signature: _____ Date: _____

I am the patient's treating & ordering provider. This order is to determine if my patient has the suspected diagnosis.

FAX TO: 833-777-2969