Sleeptopia
DON'T IGNORE THE SNORE®

Fax (888) 510-0314
orders@sleeptopia.com
Phone (316) 573-5699

FOR PATIENTS

Patient Information Sheet

Fax to (888) 510-0314

Patient Information

Please fill out completely · write N/A where applicable

FIRST NAME | LAST NAME | MI | SUFFIX | DATE OF BIRTH (MM/DD/YYYY)

GENDER ☐ Male ☐ Female ☐ Other | HEIGHT | WEIGHT | MARITAL STATUS

ADDRESS | CITY | STATE | ZIP

HOME / CELL PHONE | WORK PHONE | EMAIL

PREFERRED CONTACT ☐ Phone ☐ Text ☐ Email | EMPLOYER / OCCUPATION

EMERGENCY CONTACT | EMERGENCY CONTACT PHONE

Referring & Primary Care Physicians

REFERRING PHYSICIAN | PRACTICE / CLINIC | PHONE | FAX

REFERRING PHYSICIAN ADDRESS / CITY / STATE / ZIP

PRIMARY CARE PHYSICIAN | ADDRESS / CITY / STATE / ZIP | PHONE

Insurance Information

Please include a copy of the front and back of each card

PRIMARY INSURANCE

INSURANCE COMPANY

POLICY HOLDER NAME

POLICY HOLDER DOB (MM/DD/YYYY) | POLICY HOLDER SSN

MEMBER ID / POLICY # | GROUP #

POLICY HOLDER ADDRESS

CITY | STATE | ZIP

RELATIONSHIP TO POLICY HOLDER

SECONDARY INSURANCE *if applicable*

INSURANCE COMPANY

POLICY HOLDER NAME

POLICY HOLDER DOB (MM/DD/YYYY) | POLICY HOLDER SSN

MEMBER ID / POLICY # | GROUP #

POLICY HOLDER ADDRESS

CITY | STATE | ZIP

RELATIONSHIP TO POLICY HOLDER

Signature

PATIENT'S SIGNATURE *(or parent's signature if under 18 years of age)* | TODAY'S DATE

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FOR REFERRING PROVIDERS

Home Sleep Test Order

Fax to (888) 510-0314

Patient Information

FIRST NAME	LAST NAME	MI	SUFFIX	GENDER	DATE OF BIRTH (MM/DD/YYYY)

Prescription Rx

On room air unless specified below

HOME SLEEP TEST FOR · *select one*

- ☐ One-night home sleep test (HST)
- ☐ Two-night home sleep test (HST)
- ☐ Three-night home sleep test (HST)

OTHER TESTING OPTIONS

☐ Dental appliance ☐ PAP therapy ☐ Supplemental O_2

Sleeptopia HST devices monitor and record 7 channels: pressure flow, body position, thoracic effort, pleth, pulse rate, snore and SpO_2.

Diagnosis Codes

Select all that apply

- ☐ Excessive daytime sleepiness / fatigue (EDS G47.10)
- ☐ Obstructive sleep apnea (G47.33)
- ☐ Witnessed apneic events (G47.30)
- ☐ Sleep apnea, unspecified (G47.30)
- ☐ Snoring (R06.83)

OTHER ADDITIONAL CODES *(optional)*

Physician Authorization

I am ordering a home sleep test for the patient above based on the clinical indication(s) listed. **Dispense as checked/written.**

PHYSICIAN NAME (FIRST & LAST)	NPI *(optional)*

PHYSICIAN SIGNATURE	DATE

Additional Notes

Optional

TO AVOID ANY DELAY IN SERVICE, PLEASE INCLUDE

1. This order form
2. Patient demographics
3. Chart notes of visit

Thank you for your *referral.*

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FOR PRESCRIBING PROVIDERS

Medical Prescription & Treatment Order

Fax to (888) 510-0314

Patient Information

FIRST NAME	LAST NAME	MI	SUFFIX	GENDER	DATE OF BIRTH (MM/DD/YYYY)

Diagnosis

Length of need: 99 years = lifetime

Primary diagnosis: **Obstructive sleep apnea (G47.33)** *Also:* ☐ Nocturnal hypoxemia (G47.36) ☐ Other _____

PAP Therapy

Select one

- ☐ **Auto CPAP** E0601 — Min 5 Max 20 cmH_2O · Ramp 30 min
- ☐ **CPAP** E0601 — Pressure _____ cmH_2O · Ramp _____ min
- ☐ **Auto BiPAP** E0470 — Max IPAP _____ Min EPAP _____ PS _____ cmH_2O · Ramp _____ min
  - ☐ or standard settings: Max IPAP 15 · Min EPAP 5 · PS 4
- ☐ **BiPAP** E0470 — IPAP _____ EPAP _____ cmH_2O

Oxygen

If prescribed

- ☐ _____ liters of nocturnal oxygen bled into PAP therapy
- ☐ _____ liters of nocturnal oxygen by nasal cannula
- ☐ ONO on CPAP

Primary diagnosis for oxygen: R09.02 hypoxia/hypoxemia.

Sleep Supplies

Replacement frequencies follow the schedule shown

☐ **All related sleep supplies**, including but not limited to those below. Fit to patient comfort. *or select items*

	HCPCS	ITEM	FREQUENCY
☐	—	Mask, fit for patient comfort	1 per 90 days
☐	E0562	Heated humidifier	—
☐	A9279	Monitoring device (modem)	—
☐	A7028	Oral/mouth cushion, combination mask	2 per 30 days
☐	A7029	Nasal pillows, combination mask	2 per 30 days
☐	A7030	Full face mask	1 per 90 days
☐	A7031	Full face cushion	1 per 30 days
☐	A7032	Nasal cushion	2 per 30 days
☐	A7033	Nasal pillows	2 per 30 days

	HCPCS	ITEM	FREQUENCY
☐	A7034	Nasal / pillow mask	1 per 90 days
☐	A7035	Headgear	1 per 180 days
☐	A7036	Chinstrap	1 per 180 days
☐	A7037	Tubing	1 per 90 days
☐	A7038	Filters, disposable	2 per 30 days
☐	A7039	Filters, non-disposable	1 per 180 days
☐	A4604	Climate Line tubing	1 per 90 days
☐	A7046	Water chamber	1 per 180 days

Physician Authorization

I am prescribing the therapy and/or supplies above for the treatment of sleep-disordered breathing. **Dispense as checked/written.**

PHYSICIAN NAME (FIRST & LAST) _____ NPI *(optional)* _____

PHYSICIAN SIGNATURE _____ DATE _____

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FOR PATIENTS

Release of Information

Fax to (888) 510-0314

Patient Information

Please fill out completely · write N/A where applicable

PATIENT NAME (FIRST & LAST)

DATE OF BIRTH (MM/DD/YYYY)

HOME / CELL PHONE

WORK PHONE

EMAIL

Authorization

The undersigned, as or on behalf of Patient, request and authorize the prescribing physician, hospital, or any other holder of information relevant to my supplies, to release information upon request, to CPAP & Supplies by Sleeptopia Inc (DME) to review medical history and payer information for the purpose of providing home durable medical equipment and supplies.

By this release, I authorize any official documentation that is requested by CPAP & Supplies by Sleeptopia Inc (DME) to send and obtain information for patient listed. This information may include, but is not limited to: diagnosis, medical tests, health records, chart notes, and results of any kind.

I authorize CPAP & Supplies by Sleeptopia Inc (DME) to receive the previously listed documentation by presenting this release of information. I have been advised that any information requested and provided will be used only for official purposes by the CPAP & Supplies by Sleeptopia office in accordance with applicable laws and regulations in fulfillment of official responsibilities. Should you have questions on the validity or scope of this release, you may contact me as indicated below.

This release of information will remain in effect until terminated by me in writing.

Signature

PATIENT'S SIGNATURE *(or parent's signature if under 18 years of age)*

TODAY'S DATE

PRINTED NAME

RELATIONSHIP TO PATIENT *(if not the patient)*