Infinity Sleep Solutions

Phone: (602) 942-3777 Fax: (602) 942-2722

S.T.A.R.S. Healthcare

Phone: (480) 282-6500 Fax: (480) 282-6600

Testing Request Form

Patient Name: _____ DOB: _____

Address: _____

Gender: M / F Patient Phone #: _____ Cell: _____

Insurance Company: _____ Secondary Ins.: _____

Please be sure to include the following items with this form: Clinical Notes ▪ Insurance Info/Cards ▪ Signed Order

For your convenience Infinity Sleep Solutions/S.T.A.R.S. will obtain any prior authorization needed

Indications for Testing: Check All That Apply

□ Obstructive Sleep Apnea/Observed Apneas G47.33
□ Coronary Heart Disease I25.10
□ Unspecified Sleep Apnea G47.30
□ Hypersomnia w/Sleep Apnea G47.30
□ Excessive Daytime Sleepiness, Hypersomnia G47.10
□ Hypoxemia R09.02
□ Snoring R06.83 (Other Primary DX Required)
□ Central/Complex Apnea G47.31
□ Narcolepsy G47.419
□ Excessive Limb Movements F51.8
□ Morbid Obesity E66.01
□ Parasomnia G47.50
□ Insomnia G47.30
□ Other _____

Services/Test Ordered

□ **95810 Routine Diagnostic PSG ADULT/PEDIATRIC**

□ **95810 Routine Pediatric Diagnostic PSG (No PAP administered with ETCO2 monitoring)**

□ **95811 Split Night PSG with Titration (Initiate PAP if Medicare AHI >15/hr or >5/hr with qualifying 2nd DX)**

*** Initial for patient to return for a titration study if split night is unable to be performed or completed _____

□ **95811 CPAP/BIPAP/ASV Titration (please circle one) - Previous diagnostic study required**

□ **95805 MSLT (Daytime Study - Preceding PSG required)** □ **95805 MWT (Maintenance Wakefulness Test)**

□ **95806 Home Study - ApneaLink Plus**

□ **95807 PAP Acclimation - PAP Nap (Helpful for patients having trouble acclimating to PAP)**

□ **95808 3 Lead EEG Nap Study (Ideal for patients on CPAP or dental devices, previous sleep study required)**

□ **Sleep Consultation with a Board Certified Sleep Physician**

□ **Follow up Sleep Consultation after sleep study with a Board Certified Sleep Physician**

□ **94762 Complete Oximetry Test - Nocturnal, Rest, With Exercise On R/A then 2-4 l/m O2**

□ **94762 Nocturnal Oximetry on R/A (Default)**

DX: Hypoxia-R09.02 (for all Oximetry Tests unless otherwise specified); Length of Need: Lifetime

The information contained in this form has been completed by me or my employee & reviewed by me.
All of the information provided is true and complete to the best of my knowledge.

Physician Practice: _____ **Physician Name/Provider:** _____

Office Phone: _____ **Fax:** _____

Handwritten Signature: _____ **Date :** ____/____/____ **NPI:** _____

Infinity Locations - AASM, ACHC Accredited

15640 N. 7th St., Ste. A-1, Phoenix, AZ 85022
12133 W. Bell Rd., Ste. 101, Surprise, AZ 85378
15340 N. Northsight, Ste. 117, Scottsdale, AZ 85260
3280 S. Country Club Way, Ste. 112, Tempe, AZ 85282

S.T.A.R.S. Locations - ACHC Accredited

2350 W. Ray Rd., Ste. L101, Chandler, AZ 85224
13203 N.103rd Ave., Ste. I-7, Sun City, AZ 85351
9305 W. Thomas Rd., Ste. 465, Phoenix, AZ 85037