AccuSom® HOME SLEEP TEST provided by NovaSom®

HOME SLEEP TEST (HST) ORDER FORM: Submit via Fax to: 1-866-216-5200 or : 410-630-5845
You may also order online at **www.novasom.com/easyorder**
For assistance, please contact NovaSom at **1-877-753-3776**

For faster processing, please complete all sections below and confirm the patient's current phone number.
PLEASE NOTE: Patients who cannot be removed from oxygen or CPAP to administer the AccuSom Home Sleep Test overnight should have an attended, in-lab sleep test. By sending this order to NovaSom, you are attesting that the patient can have a Home Sleep Test.

PRESCRIBER INFORMATION			
Ordering Provider Name:	Phone #:	Fax #:	NPI (If this is provider's first order):
Office Contact Name:		Phone# (If applicable, include extension #):	

PATIENT INFORMATION			
Last Name:		First Name:	
Date of Birth (mm/dd/yyyy):	Gender: ☐ Male ☐ Female	Height:	Weight:
Address **(Include apartment #. Unable to deliver to a P.O. Box):**			
City:		State:	Zip code:
Primary Phone (include area code):	Alternate Phone:		Language (if not English):

PAYMENT/INSURANCE

MUST CHECK ONE:
Patient requests **self-payment of $297**: ☐ Charged in three (3) credit card installments of $99 each.
Patient requests **insurance billing**: ☐ ***Attach copy of both front & back of insurance card and complete section below.***

Primary Plan:	Subscriber ID:	Policy Holder Name:	Policy Holder Birth Date:
Secondary Plan:	Subscriber ID:	Policy Holder Name:	Policy Holder Birth Date:

DIAGNOSIS/MEDICAL HISTORY/SYMPTOMS

ICD-9 Code 327.23/ICD-10 Code G47.33 will be used for this Obstructive Sleep Apnea (OSA) test unless specified otherwise. (If other, specify):

Medical Necessity of Home Sleep Testing:
1. Certain Payers require as many as four (4) symptoms but at least two (2). Please check all that apply.
2. Certain Payers require medical documentation/progress notes regarding testing for Sleep Apnea. Please attach these.

☐	Hypertension	☐	Habitual Snoring	☐	Previous Diagnosis of OSA
☐	Witnessed Apneic Events	☐	Irritability/Moodiness	☐	Assessment of Efficacy of Surgery
☐	Witnessed Nocturnal Motor Activity	☐	Morning Headaches	☐	Assessment of Oral Appliance
☐	Fatigue	☐	Daytime Sleepiness/Napping	☐	Assessment of Efficacy of Other Treatment
☐	Gasping/Choking	☐	Drowsy Driving	☐	Other (Specify):

Enter Epworth Sleepiness Scale Score (Range 0 – 24; ≥ 10 = High Risk):

TEST TYPE - *Home Sleep Test Only will be administered if nothing is checked below.*

☐	Home Sleep Test Only (An up to three-night Sleep Test will be administered based upon ordering provider or payer)		
☐	Home Sleep Test including Titration Test; if patient is positive for Obstructive Sleep Apnea.		
☐	Titration Test Only	If Sleep Test **was not** done by NovaSom, supply date of last Sleep Test:	AHI:

DESIGNATED THERAPY/DURABLE MEDICAL EQUIPMENT (DME) PROVIDER AND RELEASE OF TEST RESULTS
By entering contact information below, provider directs that any test results (whether positive or negative) additionally be sent to the therapy/DME provider for purposes of treatment of the patient.

Therapy/DME Provider Name:	Phone #:	Fax #:

By signing below, I attest that: upon my examination of the patient, which included HEENT, Cardiovascular, Chest/Lung, Neurological and Vital Signs, there is a high probability of OSA. A Home Sleep Test is medically necessary and no co-morbid conditions are present that prevent the patient from home testing.

Provider's Original Signature (Stamped Signatures Not Accepted) **Date**