



PHYSICIANS ORDER FOR HOME SLEEP TEST

Depot Drug Testing

P.O. Box 165090 Salt Lake City, UT 84116- (800) 877-0618

Fax Completed Form to: (801) 595-2051



PATIENT Last Name: _____ First Name: _____

Delivery Address: _____

City: _____ State: _____ Zip: _____

Phone: Day: (____) - _____ Evening: (____) - _____ Alt: (____) - _____

Birth Date: ____/____/____ Circle Gender: Male - Female Height: _____ in. Weight: _____ lbs

EMPLOYER NAME: _____

INSURANCE: ID Number: _____ Attach a copy of primary insurance card.

ASSIGNMENT OF BENEFIT: PLEASE HAVE PATIENT SIGN IF POSSIBLE WHILE IN PHYSICIAN OFFICE

I the undersigned authorize and release Depot Drug to bill my insurance on my behalf for the costs of testing and equipment. I authorize and request my insurance to pay Depot Drug the amount due to me under the terms of my policy as a result of the medical services rendered. I understand that I am responsible for denial, deductible, and/or co-payment.

Patient Signature: _____ Date: ____/____/____

CPAP/HOME MEDICAL EQUIPMENT SUPPLIER: The following is a local preferred supplier of Home Medical Equipment that may be used to treat your medical condition based on the results obtained through the test on this order form:

Company: _____ Phone: _____

MEDICAL RECORDS RELEASE (Only valid if Home Medical Equipment Company is listed above): I, undersigned, authorize Depot Drug to release my medical information on this test order as well as the results of this test, from my medical records file to the company listed above as the "CPAP/Home Medical Equipment Suppliers".

Patient Signature: (Optional) _____ Date: ____/____/____

ORDERING PHYSICIAN: NPI (REQUIRED) _____

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____

Fax: (____) - _____ Phone: (____) - _____

PROCEDURE ORDER: Home Sleep Test and Therapy with Auto CPAP Home Sleep Test Only (CPT 95806)
 CPAP Therapy Only

DIAGNOSIS: PHYSICIAN OFFICE ONLY- MUST CHECK DIAGNOSIS CODE AND SIGN AND DATE

327.23 Obstructive Sleep Apnea or other code w/description Other: _____

I the undersigned understand that by completing the form and signing below that I am ordering a Home Sleep Test for patient listed above and that the patient or the insurer is responsible for testing fees. I also understand that Medicare coverage guidelines require a face-to-face clinical evaluation for Obstructive Sleep Apnea to be documented in the patients chart prior to home sleep test.

PHYSICIAN SIGNATURE : _____ DATE: ____/____/____