The REM Center™

4364 7th Street
Moline, Illinois 61265
Ph. 309.762.2998 Fax 309.762.2919 or 563.594.5196

Name: _____ *Phone:* _____

DOB: _____ *SS#:* _____

Diagnosis:

( ) *Other hypersomnias* ***G47.19***
( ) *Other sleep disorders* ***G4.8***
( ) *Insomnia, unspecified* ***G47.00***
*** ( ) *Sleep apnea, unspecified* ***G47.30***
( ) *Other fatigue* ***R53.83***
( ) *Snoring* ***R06.83***
( ) *Somnolence* ***R40.0***
( ) *Obstructive sleep apnea* ***G47.33***
( ) *Narcolepsy* ***G47.411***
( ) *Periodic limb Movements of sleep* ***G47.61***

******Indicates "best" code for insurance purposes – please use if it applies to patient***

Procedure:

( ) *Home Sleep Study* ***(95800/G0399)***
( ) *Baseline Sleep Study* ***(95810)***
( ) *Sleep Study with CPAP Titration if indicated – split night* ***(95811)***
( ) *Sleep Study with CPAP Titration* ***(95811)***
( ) *Multiple Sleep Latency Test (MSLT) / Maintenance of Wakefulness Test (MWT)* ***(95805)***
( ) *Sleep Clinic Evaluation*

PLEASE SEND MOST RECENT OFFICE NOTES, DEMOGRAPHICS & INSURANCE CARD FOR PATIENT. THANKS

Other comments:

_____

_____

_____

WITH MY SIGNATURE, THE ABOVE IS AN ORDER AND INDICATES MEDICAL NECESSITY:

_____

Physician Signature Date

(Ordering Physician Signature MUST be present on all orders)

PHYSICIAN INFORMATION: ***(FOR FIRST TIME REFERRALS ONLY)***

*NAME:*_____ *PHONE:*_____ *FAX :*_____

*ADDRESS*_____ *CITY*_____ *STATE*___ *ZIP*_____

*NPI #*_____ *TAX ID#*_____

PRACTICE NAME/SPECIALTY:_____