Infinity Sleep Solutions
"A better night's sleep."
Phone: (520) 207-8884 Fax: (520) 207-9746

S.T.A.R.S. Healthcare
"Where patients are our priority."
Phone: (520) 918-1316 Fax: (520) 918-1347

Sleep Testing Request Form

Patient Name: _____ DOB: _____
Address: _____
Gender: M / F Patient Phone #: _____ Cell: _____
Insurance Company: _____ Secondary Ins.: _____

Please include the following with your order: Clinical Notes ▪ Insurance Info/Card(s) ▪ Signed Order

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

Indications for Testing

□ Obstructive Apneas/Witnessed Breathing Pauses G47.33
□ Primary Central/Complex Sleep Apnea G47.31
□ Unspecified Sleep Apnea G47.30
□ Hypersomnia, Unspecified G47.10
□ Excessive or Abnormal Body/Limb Movements G47.61
□ Habitual Choking, Gasping, Night sweats G47.30
□ Central/Complex Apnea G47.61
□ Excessive Daytime Sleepiness G47.10
□ Narcolepsy G47.419
□ Other _____

Services/Tests Ordered

□ **95810 Diagnostic PSG**
□ **95810 Pediatric Diagnostic PSG (No PAP administered: ETCO2 monitored - Ages 6+)**
□ **95811/95810 Split Night PSG with Titration (Initiate PAP if MCR 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 _____
□ **If in-lab study is denied, proceed with Home Sleep Study (HST)**
□ **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 Sleep Study (HST)**
□ **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 before sleep study with a Board Certified Sleep Physician**
□ **Follow-up Sleep Consultation after sleep study with a Board Certified Sleep Physician**

Special Instructions:

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 Location
5983 E. Grant Road
Suite 105
Tucson, AZ 85712

S.T.A.R.S. Location
1951 N. Wilmot Road
Building 1, Unit 4
Tucson, AZ 85712

ACHC Accredited