

## Certificate of Medical Necessity

Patient (Last, First, MI) \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Insurance Carrier/ ID# \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_  
 Patient Address \_\_\_\_\_ Home Phone \_\_\_\_\_ ( ) \*  
 \_\_\_\_\_ Work Phone \_\_\_\_\_ ( ) \*  
 \_\_\_\_\_ Cell Phone \_\_\_\_\_ ( ) \*  
 Email \_\_\_\_\_ (\*indicated preferred number to contact)  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ (or BMI) \_\_\_\_\_ Epworth Score \_\_\_\_\_ Male  Female

<input type="checkbox"/> <b>HOME SLEEP STUDY 1</b> w/ Certified Sleep Physician Interpretation  <b>"HIGH PROBABILITY OF OSA"</b>  (ESS≥10, BMI≥30 & symptoms (√ below))	<input type="checkbox"/> <b>HOME SLEEP STUDY 2</b> w/ Certified Sleep Physician Interpretation  <b>FOLLOW UP</b>  Indication(Circle): CPAP* OAT* Surgery Weight Loss *Perform Study W <input type="checkbox"/> W/O <input type="checkbox"/> Therapy	<input type="checkbox"/> <b>HOME SLEEP STUDY 3</b> w/ Certified Sleep Physician Interpretation  <b>OSA Suspected</b> Patient Pay  (Non-conforming Sleep Parameters)	<input type="checkbox"/> <b>HOME SLEEP STUDY 4</b> Comprehensive Sleep Study Report w/o Interpretation  <b>OSA Screening</b> Patient Pay  Quantification by Qualified physician for snoring/treatment
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Does patient have a permanent pacemaker?  Yes  No  
 Is the patient on Oxygen?  Yes\*\*  No  
 \*\*If Yes - is on room air testing approved?  Yes  No

<input checked="" type="checkbox"/> <b>Sleep History / Conditions / Symptoms (check all applicable - at least one)</b>							
<input type="checkbox"/>	Loud, Disruptive Snoring	<input type="checkbox"/>	Ischemic Heart Disease	<input type="checkbox"/>	Impaired Cognition	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Witnessed Apnea > 10 sec. by _____	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	Morning Headaches	<input type="checkbox"/>	Elongated Soft Palate
<input type="checkbox"/>	Gasping or Snorting (During Sleep or Upon Waking Up)	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Nasal Obstruction
<input type="checkbox"/>	Excessive Daytime Sleepiness	<input type="checkbox"/>	History of Stroke	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	Swollen Turbinates
<input type="checkbox"/>	Please list any medications taken:						

Primary Diagnostic ICD-10 Code (check only one)		
<input type="checkbox"/> G47.33 Obstructive Sleep Apnea (Adult & Pediatric)	<input type="checkbox"/> G47.30 Unspecified Sleep Apnea	<input type="checkbox"/> R06 General Snoring

**PATIENT'S INSURANCE INFORMATION:** \*Attach copy of front and back of insurance card\*

**PATIENT'S SIGNATURE TO AUTHORIZE INSURANCE BILLING:**

By signing below, I acknowledge that I have received and read 1st Line Medical, Inc.'s Policy Statement including Instructions For Use, return of the diagnostic system, potential financial obligations and give permission to 1<sup>st</sup> Line Medical, Inc. to conduct the diagnostic service and submit a claim to my health insurer if applicable.

\_\_\_\_\_  
**Patient Signature** \_\_\_\_\_ **Date**

\_\_\_\_\_  
**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Physician Name (printed)**

**Submit via Fax #: 800-918-7860**

Phone Number: 866-720-8080



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (eg a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

To check your sleepiness score, total the points.

### EPWORTH SLEEPINESS SCALE KEY

1 - 6	Your score is low
7 - 8	Your score is average
9 and up	Seek the advice of a sleep specialist without delay

### Weight (lbs)

	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300
5'0"	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	57	59
5'2"	22	24	26	27	29	31	33	35	37	38	40	42	44	46	48	49	51	53	55
5'4"	21	22	24	26	28	29	31	33	34	36	38	40	41	43	45	46	48	50	52
5'6"	19	21	23	24	26	27	29	31	32	34	36	37	39	40	42	44	45	47	49
5'8"	18	20	21	23	24	26	27	29	30	32	34	35	37	38	40	41	43	44	46
5'10"	17	19	20	22	23	24	26	27	29	30	32	33	35	36	37	39	40	42	43
6'0"	16	18	19	20	22	23	24	26	27	29	30	31	33	34	35	37	38	39	43
6'2"	15	17	18	19	21	22	23	24	26	27	28	30	31	32	33	35	36	37	39
6'4"	15	16	17	18	20	21	22	23	24	26	27	28	29	30	32	33	34	35	37