

PATIENT INFORMATION

Name: _____ Gender: _____ DOB: (mm/dd/yyyy) _____
 Address / City / State / Zip: _____
 Home Phone: _____ Cell Phone: _____ Email: _____
 Preferred Written / Spoken Language: _____ Emergency Contact / Number: _____
 Primary Payer: _____ ID#: _____ Group: _____ Phone: _____
 Secondary Payer: _____ ID#: _____ Group: _____ Phone: _____
 Height: _____ Weight: _____ BMI: _____ Neck Size: _____ Sleep Epworth: _____

PRESCRIBER INFORMATION

Name: _____ Address / City / State / Zip: _____
 Phone: _____ Fax: _____ NPI: _____
 Referral Coordinator: _____ Phone: _____ Email: _____

HOME SLEEP APNEA TEST

Sleep Apnea Test: *Room Air up to 2-night unattended portable recorder with min (4) channels eg: records airflow, respiratory effort, POX / HR*
 Sleep Apnea Test Diagnosis: Obstructive Sleep Apnea G47.33 Sleep Apnea Unspecified G47.30 Other: _____
 Sleep Apnea Test Symptoms: Excessive Daytime Sleepiness Snoring Observed Apneas: Other: _____
 Other Sleep Apnea Test Orders: _____

How to use this form:

This form should primarily be used to diagnose first time CPAP users or for a renewed diagnosis when a renewed diagnosis is required.

1. Fax this form along with the supportive chart notes indicating suspected OSA. An Epworth or equivalent questionnaire is also helpful.
2. Benefits and documentation will be verified and if acceptable, your patient will be contacted by Virtuox and a device will be sent to them via 2 day delivery. Virtuox will contact your office if more documentation is required.
3. The patient will use the device for 2 nights in the comfort of their home and then upload the data via Bluetooth through their smart phone. If the patient does not have a smart phone, a 2 day return label is provided for them.
4. The study results will be reviewed by a board certified sleep practitioner and test results are sent to your office.
5. If therapy is needed, a prescription is generated for you to sign.
6. The signed prescription goes to Remedy Medical Supply to set your patient up on PAP therapy.
7. Benefits and documentation are verified and the patient is contacted for a set up appointment.

Your patient can go from testing to therapy in as little as two weeks. No long waits for a lab appointment.

This form is for Medicare, Medicare Advantage, PPO, and EPO patients only. Virtuox is contracted with most major plans.

NOT VALID FOR MEDI-CAL/MEDICAID PAYERS OR HMO PLANS/IPA PLANS

PRESCRIBER SIGNATURE

Signature: _____ Date: _____

Please fax completed order form, demographics & insurance card to **888-635-8380**