# In-Lab/Attended Sleep Study Authorization Form

**Please note: This form must be completed in full. Authorization requests will not be processed without required information, including supporting documentation.**

**Authorization is not required for patients ages 17 or younger, or patients covered by Medicare Parts A and B, or other primary coverage.**

**Home Sleep Testing studies do not require preauthorization.**

Date of request: ______________________ Anticipated service date: ____________________
[minimum 15-day turnaround time (TAT)]

Patient name: ____________________________ Phone: ____________________________

ID number: ______________________ Date of birth: ________________ Age: ___

Member address: ____________________________________________________________

____________________________________________________________

Requesting physician: ____________________________ Tax ID: ______________________

Address: ____________________________________________________________

____________________________________________________________

Contact name: ____________________________________________________________

Phone: ______________________ Ext: _________ Fax: ______________________

Email: ____________________________ Number of pages: ____________________

Primary diagnosis ICD-10: ____________________________

Additional: ____________ ____________ ____________ ____________ ____________

***Only these codes require preauthorization***

Requested test – please check: 95805 95807 95808

95810 OR 95811 (choose one, cannot choose both)

**Home Sleep Testing, including home CPAP/APAP titration, does not require preauthorization.**

(form continues on next page)

GEHA

**Note: Attended sleep studies will require evidence of one of the following.**
**Please check the appropriate condition and submit the specific documents noted below:**

☐ Severe CHF

- Date of echocardiogram: ____________________
- Ejection fraction: ____________________
- Evidence of diastolic dysfunction: ____________________
- Functional classification: ____________________

☐ Seizure disorder

- Type of seizures
  - Grand mal: ____________________
  - Complex partial: ____________________
- Date of last seizure: ____________________

☐ Severe COPD – submit the following:

- Pulmonary function tests (PFTs). Please include report.
  - Resting arterial blood gas on room air: ____________________
  - FEV1: ____________________
  - Actual: ____________________
  - Predicted: ____________________
  - Percentage: ____________________

☐ Alveolar hyperventilation syndrome – submit the following:

- Pulmonary function tests (PFTs): ____________________

☐ Periodic limb motion disorders (PLMs) – submit the following:

- Describing how PLMs are injurious to patient or sleeping partner: ____________________
- Frequency: ____________________

☐ Type of severe neuromuscular disease

- Multiple sclerosis: ____________________
- Parkinson's: ____________________
- Spinal cord injury: ____________________
- Residual CVA: ____________________
- Myasthenia gravis: ____________________
- Other – please submit description of functional deficits

(form continues on next page)

☐ Normal HST in a patient with a high pretest probability of OSA – list factors used in determination:

- STOP-Bang score: ____________________________
- Neck circumference: _________________________
- BMI __________________________
- ESS: _________________________
- Witnessed apneas: ___________________________
- EDS: _________________________
- Overnight oximetry: __________________________

☐ Presence of significant central apneas – submit prior sleep study documentation:

- Date of study: ________________________
- Type of study; attended/home: ______________________________
- Number of events and Central Apnea Index: _________________________
- AHI: _________________________

☐ Physical and or mental incapacity to perform an HST

- Type of disease: _____________________________
- Description of deficits: _____________________________________________________________________

☐ If MSLT (95805) requested, send documentation of narcoleptic symptoms.

- Sleep paralysis
  - Hypnotic hallucination: ______________________________
  - Cataplexy: ___________________________
  - Unrefreshed sleep: ___________________________
  - Lack of response to CPAP/APAP therapy: ____________________________
  - Document compliance with CPAP download report: _________________________
  - Type of residual symptoms: _________________________
  - Hours Used (CPAP/APAP) nights per week: _________________________

**Please fax completed form to 816.257.4516***

***If the patient lives in Texas, call United Healthcare Choice Plus at 877.585.9643.**

Questions? Call GEHA at 800.821.6136

For help ordering a Home Sleep Test, call HOMELINK at 800.482.1993.

All benefit payments are subject to review for any applicable deductibles, coinsurance, maximums, medical necessity and patient eligibility on the date that the service is provided or the supply delivered.