

Foundation Authorization Request for SLEEP STUDY (CPT 95811)

Fax Completed Form to 707-442-2047 or Mail to the Foundation, P.O. Box 1395, Eureka, CA 95502

Incomplete request forms will be returned without being processed.

Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

Foundation Authorization Tracking Number:

MEMBER INFORMATION

Patient Name: _____ Gender: M / F Date of Birth: _____

Patient's Address: _____

Street _____ City _____ Zip _____

Phone: _____ Health Plan: HMO: Anthem Blue Cross CaliforniaCare HMO/POS - Blue Shield Cal PERS HMO
PPO: Blue Lake Rancheria - Open Door Community Health Centers - SJHS-Humboldt - Trinidad Rancheria

Subscriber Name: _____ Group #: _____

Member's Primary Care Provider: _____ Subscriber #: _____

REQUESTING PROVIDER INFORMATION

PROPOSED PROVIDER & FACILITY INFORMATION

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Contact Name: _____ Tax ID # (Out of Area Providers only): _____

Today's Date: _____ Place of Service: _____

REQUEST FOR SLEEP STUDY – MEDICAL NECESSITY - (CPT 95811)

1. Is this being requested for suspected Obstructive Sleep Apnea? If not, what condition(s) are being evaluated?	ICD-9 code:	Height:	Weight:
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2. **Is this an initial request or a repeat?**
If repeat, Date of last Sleep Study _____ and attach resultt

3. **Are there witnessed apnea episodes at night?** *Describe:*

4. **Fitful sleep / awakening episodes?** *Describe:*

5. **Excessive daytime fatigue?** (Epworth Sleepiness scale, etc.) *Describe / document specific instances:*

6. **Loud snoring at night ?** (Do people make comments about it) *Describe:*

7. **Hypertension or other cardiovascular disease?** *List:*

8. **Abnormal ENT exam (uvula, soft palate, tonsils, nasal patency)?** *Describe:*

9. **Other pertinent risk factors / symptoms etc.**

- Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed. Providers must verify member eligibility within 5 days of the date of service to ensure coverage..
- Claims for services rendered without required prior authorization may be denied reimbursement. Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
 - The requesting physician or the member may submit authorization appeals to the Foundation Medical Management Department.
 - This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety Code §1370, and California Evidence Code §1157.

CONFIDENTIAL INFORMATION

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