HealthPartners® **Medical Review Form**

Portable / Unattended / Home Sleep Tests (HST)

Quality and Utilization Improvement Dept.	**Telephone # (952) 883-5741**
Medical Policy - DME	**Fax # (952) 853-8714**

Member Name:	**Date of Birth:**	**Member #:**
Completed by:	**Phone #:**	**Fax #:**

Ordering Physician Name/Specialty (please print):
_____

NPI #_____

Clinic / Facility: _____
TAX ID #_____

Date Form Completed: _____
Date of Obstructive Sleep Apnea (OSA) clinical evaluation: _____
Diagnosis & ICD 9 code: _____

 # Nights HST is requested_____

Is this a request for Medicare services? **Yes____ No____

Location where HST will be performed: In patient's home_____ Health care facility_____
Name of HST device: _____

*****NOTE for Medicare services:***
CPT codes 95800, 95801 or 95806 will only be allowed when performed in a facility
HCPCS codes G0398, G0399, or G0400 are to be used when HST is performed in the home

HCPCS Code requested:
G0398 -Type II device ____ G0399-Type III device ___ G0400-Type IV device (covered for Medicare only**)** _____
OR
CPT Code requested:
95800_____ **95801**_____ **95806**_____

A) For non-Medicare requests, HST must be ordered by a physician who meets one of the following criteria (please check one):

☐	1. MD Diplomate of the American Board of Sleep Medicine (ABSM), Pulmonologist, Neurologist (Name of physician):_____
☐	2. MD with current Sleep Certification issued by one of the following Boards: American Board of Internal Medicine (ABIM), American Board of Family Medicine (ABFM), American Board of Pediatrics (ABP), American Board of Psychiatry and Neurology (ABPN), American Board of Otolaryngology (ABOto) (Name of physician):_____

B) For all requests, HST must be read and interpreted by a physician who meets one of the following criteria (see #1-2 below for non-Medicare requests, OR #1-3 for Medicare requests)

☐	1. MD Diplomate of the American Board of Sleep Medicine (ABSM), Pulmonologist, Neurologist (Name of physician):_____
☐	2. MD with current Sleep Certification issued by one of the following Boards: American Board of Internal Medicine (ABIM), American Board of Family Medicine (ABFM), American Board of Pediatrics (ABP), American Board of Psychiatry and Neurology (ABPN), American Board of Otolaryngology (ABOto) (Name of physician):_____

OR (Medicare requests only):

☐	3. MD with active staff membership in a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission (Name of Sleep Center or lab):_____

I confirm that the information above is correct.
Physician Signature: _____**Date:**_____