

Sleep Data, Inc.
FAX REFERRAL FOR SLEEP STUDY

ESSENTIAL INFORMATION:

Ordering Physician: _____

If not on file:

Physician License #: _____ UPIN #: _____

Office Address: _____

Office Phone #: _____ Fax #: _____

Patient Name: _____

Patient Address: _____

Patient City, State, Zip: _____

Patient Phone #: Day: _____ Evening: _____

Patient Date of Birth: ____/____/____

Reason for test: _____

Special requests (e.g. "Test on 2.0 L/M O2 via nasal cannula; test on CPAP 8cmH2O"):

INFORMATION WHICH WILL EXPEDITE PATIENT TESTING:

Patient SS#: _____

Primary Insurance: _____

Policy #: _____ Group #: _____

Employer: _____

Insurance phone #: Pre-Auth.(____) _____ Benefits (____) _____

Claims Address: _____

Policyholder Name: _____

SSN#: _____ Date of Birth: ____/____/____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Claims Address: _____

Insurance phone #: Pre-Auth.(____) _____ Benefits (____) _____

Policyholder Name: _____

SSN#: _____ Date of Birth: ____/____/____

Pre-auth. info: _____

Benefits: eff. date: ____/____/____ % UCR (in-net.) % UCR (out-net.)

\$ _____ ded. (met/not met) Contact person: _____ on ____/____/00

For Immediate Service Fax To:

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TEL: (619) 299-6299 (800) 619-4672