SLEEP STUDY PRECERTIFICATION REQUEST FORM
cigna.sleepccx.com
Phone: 877.877.9899 Fax: 866.536.5225

This form must be completed in its entirety for all faxed sleep services precertification requests. The most recent clinical notes must also accompany the faxed request. We recommend that all requests for sleep related services are submitted via our website at cigna.sleepccx.com, you can access our provider portal to submit and upload this document at: https://www.carecentrixportal.com/ProviderPortal/homePage .

Patient Name:	Cigna ID #:	Date of Birth:
Patient Address:	City:	State/Zip:
Home #:	Cell #:	Work #:
Height:	Weight:	BMI:
Ordering Healthcare Professional:	Ordering Healthcare Professional NPI :	
Ordering Healthcare Professional Address:	City:	State/Zip:
Ordering Healthcare Professional Phone #:		Ordering Healthcare Professional Fax #:

I. ICD-10 Diagnosis Code(s): 1.) _____ 2.) _____ 3.) _____ 4.) _____

II. Study Requested:

Unattended Home Sleep Test (HST)?

G0399 _____ G0398 _____ 95800 _____ 95801 _____ 95806 _____

Facility diagnostic sleep test?

____ **95807 Diagnostic PST, abbreviated study (note this is normally not covered by Cigna)**
____ **95808 Diagnostic PSG (3+ parameters)**
____ **95810 Diagnostic PSG (4+ parameters)**
____ **95782 Diagnostic PSG age < 6 years**
____ **95811 Split-Night PSG attended w/therapy**

If an attended diagnostic study is requested and a home sleep test (HST) is approved, may the HST be substituted?
Yes ____ No ____ If **No**, please provide reason and select co-morbidity (Section IV C) with supportive clinical evidence attached.

Facility follow-up (second night) sleep test?

(Please provide previous diagnostic test raw data)
____ **95811 Full-Night Titration Study (CPAP)**
____ **95811 Full-Night Titration Study (Bi-level)**
____ **95811 Full-Night Titration Study (Bi-level w/ ASV)**
____ **95783 Full-Night Titration Study age < 6 years**
____ **95805 Multiple Sleep Latency Testing / PSG (MSLT)**
____ **95805 Maintenance of Wakefulness Test (MWT)**
If an attended titration study requested, but only auto-titrating positive airway pressure machine (APAP) is approved, may the APAP be substituted? Yes____ No____ If **No**, please provide reason and select co-morbidity (Section IV C) with supportive clinical evidence attached.

III. Rendering Facility / Qualified Healthcare Professional

Billing Facility Name: _____ Address: _____

Phone: _____ Fax: _____ Tax ID: _____ NPI:_____

HST Provider: _____ Address: _____

Phone: _____ Fax: _____ Tax ID: _____ NPI: _____

IV. Clinical Information – Check all that apply

A. What is the indication (suspected diagnosis) for the sleep study?

___ Obstructive Sleep Apnea (OSA) (G47.33)
___ Central or treatment-emergent sleep apnea (G47.31, G47.37)
___ REM sleep behavior disorder (G47.52)
___ Narcolepsy (G47.411, G47.419)
___ Other – Please Specify: _____

B. Complaint(s), Sleep Testing

___ Disruptive snoring (R06.83)
___ Disturbed or restless sleep
___ Non-restorative sleep
___ Excessive Daytime Sleepiness (EDS)
___ Witnessed apnea events
___ Choking during sleep
___ Gasping while sleeping
___ Frequent unexplained arousals from sleep
___ Periodic Limb Movement Disorder (PLMD) diagnosed on previous polysomnography (G47.61)
___ Insomnia (G47.00)
___ History of OSA on PAP or other therapy

How long has the patient experienced these symptoms? _____

Is this a request for a repeat sleep study? Yes ____ No ____If yes, date of last sleep study: _____

If the patient had a prior sleep study, what sleep disorders was the patient previously diagnosed with? _____
Submit previous sleep study

Repeat study indication: Change in BMI >10% _____ Recent T/A or UPPP _____ Other _____
Compliance for repeat studies: PAP used > 2 mos. Yes ____ No ____ 70% of usage 4+ hours per night? Yes ___ No ____

Submit PAP compliance report

C. Co-morbid Conditions (Diagnostic and Follow-Up Testing):
___ Impaired cognition/dementia
___ Unexplained pulmonary hypertension, documented pulmonary artery pressure greater than or equal to 40 mm Hg
___ Moderate to severe congestive heart failure, documented NYHA Class III or IV
___ Diagnosed significant acute cardiac arrhythmia not controlled by medication
___ Moderate to severe pulmonary disease as demonstrated on pulmonary function studies
___ Known neurodegenerative disease
___Uncontrolled seizure disorder

D. Epworth Sleepiness Score (ESS) (Required):
Use the following scale to choose the most appropriate number for each situation:
0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation Chance of Dozing or Sleeping	**Scale**
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (without alcohol)	
Sitting for a few minutes in traffic while driving	
Total Score equals your ESS	

0 - 9 Average score, normal population

V. Special Needs:

Occupational or social limitations (please specify): _____

Alternate Language Spoken (please specify): _____

VI. Medications:

Please attach a complete list of the patient's current medications, including over-the-counter (OTC) medications, and indicate if any of the medications are pain control or sedating medications.

PHYSICIAN or QUALIFIED HEALTHCARE PROFESSIONAL'S SIGNATURE

X _____

Type/print name and date

X _____

No signature stamps allowed.

By signing this request, the physician or qualified healthcare professional verifies that the information reported is true and accurate.