In-Lab/Attended Sleep Study Authorization Form

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Purpose of this form

You can use this form to initiate your precertification request. The form will also help you know what supporting documentation is needed for GEHA to review your request.

You can find our coverage policies at **Provider resources**. These will allow you to see the criteria used to determine medical necessity and procedures that are not allowable.

For us to review your request properly and to avoid delay, you must complete all sections of the form and provide the necessary supporting documentation. If you have questions about the form or need help, you can speak with a surgical specialist at 800.821.6136, ext. 3100.

After you have completed the form

Preauthorization reviews are completed within 15 days from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health or ability to regain maximum function. Post-service reviews are completed within 30 days.

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.

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

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: ___________________________

Preferred pronouns: ____________________________ (optional)

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 95808

95810 OR 95811-titration only OR 95811-split night study

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

(form continues on next page)

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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)

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☐ 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

Questions: Call GEHA at 800.821.6136

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.