betternight

Provider Name:

Phone: (866) 801-9440
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Sleep Medicine Referral Form & ICD-10 Codes for Services

Section 1: Patient Information (required)

Patient Name:

Address, City, State, Zip:

Date of Birth:

Home Phone:

Cell Phone:

Email:

Referring Physician:

Address, City, State, Zip:

Phone:

Fax:

Email:

National Provider Identifier:

Section 2: Sleep Disorders/Diagnostic Services (required)

☐ Baseline Home Sleep Test (HST)

Section 3: Symptoms & Reason For Referral (Please attach recent consult notes)

☐ **G47.10** Hypersomnia, unspecified
☐ **G47.13** Recurrent hypersomnia
☐ **G47.14** Hypersomnia due to medical condition
☐ **G47.30** Sleep Apnea, unspecified
☐ **G47.33** Obstructive Sleep Apnea (adult/pediatric)
☐ **G47.19** Other hypersomnia

Practitioner Signature:

Special Requests:

Date:

Patient Insurer Name and Insurance ID#:

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