MID-SOUTH SLEEP DISORDERS CLINIC

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Certificate of Medical Necessity

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Presenting Diagnosis:
_____

Type of Study to Be Performed, please check ALL the following that apply:

95810 ☐ Full Polysomnography greater than six hours (**all night study**)

95811 ☐ Nasal CPAP, BILEVEL or ADVANCED **Titration Study**

95806 ☐ Unattended Sleep Study (**Home Sleep Study**)

95811 ☐ PAP Follow-Up/Re-Titration Study

95810 ☐ Surgical Follow-up

95805 ☐ Maintenance of Wakefulness Test (**MWT**)

95805 ☐ Multiple Sleep Latency Test (**MSLT**)

95807 ☐ PAP NAP (For patients having problems tolerating their PAP machine/PAP Mask)

☐ Other _____

____YES ____NO Is this patient currently on oxygen? If so, how many liters? _____
____YES ____NO Do you want oxygen administered during the study? If so, what oxygen saturation would you like to maintain? _____

Physician Name (Print): _____

Physician Signature: _____