Sleep studies, home studies,
Consulation and
cPAP setup and cPAP
Clinics

PIEDMONT
SLEEP CENTER, INC.
EXCELLENCE IN SLEEP MEDICINE

LKN
DME

A Division of Lake Norman Sleep Center

Certificate of Medical Necessity

Dr. Sever Surdulescu, Medical Director (Lake Norman Pulmonary)
Board Certified in Sleep Medicine
www.piedmontsleepcenter.com

New Location
1070 Lenoir Rhyne Blvd SE
Hickory, NC 28602
(Lower Level of Eye Care Center)

Both Locations
828-322-3111 Phone
828-322-3160 Fax

302 Mulberry St SW
Lenoir, NC 28645
(Across from Caldwell Memorial Hospital)

Physician's Name _____

Physician's NPI # _____

Nurse/Contact Person _____

Phone_____Email_____

Fax_____

(check all that apply):

- ☐ R/O OSA ☐ HKTN
- ☐ H/O CHF ☐ H/O CVA
- ☐ Severe Snoring
- ☐ Sleep Disturbance
- ☐ Pulmonary HTN
- ☐ H/O Ischemic Heart Disease
- ☐ Evaluate for Narcolepsy
- ☐ Hypersomnia/Excessive Daytime Sleepiness

Test To Be Performed:

- ☐ **95810-PSG in sleep lab** **Height**_____
- ☐ **95811-Split sleep study in sleep lab**
- ☐ **95806-Home sleep study PSG** **Weight** _____
- ☐ **95811-CPAP sleep study in sleep lab**
- ☐ **95805-Multiple Sleep Latency-MSLT** **BMI**_____

(Order MSLT) NOTES:_____

_____

***DIAGNOSIS CODES (ICD-9):**_____

***Patient's Name & Date of Birth**_____

***Please fax us insurance card (front and back), patient demographics, and any clinical notes. *Note: You may also send your script with patient's name, test to be performed, along with patient demographics. This is also an acceptable order.**

*****If PSG is positive for OSA, may we proceed with a CPAP titration study? Yes_____ No _____**

(Hickory only)

Would you like patient to have a follow-up consultation with Dr. Surdulescu to go over sleep study results & set up at a DME?

Yes_____ No _____

Referring Physician will follow-up after sleep study and set up at a DME. Yes_____ No _____

I certify that I am the treating physician identified in Section A. I have the Certificate of Medical Necessity and any statement here has been reviewed and signed by me. I certify that the medical necessity information in Section B is true and accurate and complete, to the best of my knowledge. I certify that the above test ordered is medically necessary in the treatment of this patient. This sleep study includes tape, electrodes, in lab DME cPAP titration equiptment, headboxes, paste cPAP mask, tubing and all supplies needed to fill prescription order by Physician if needed.

PHYSICIAN'S SIGNATURE _____

DATE_____