Seton Health Plan

A member of the Seton Healthcare Family

Pre-Certification Form
Medical Management Dept.
Phone #: (512) 324-3135
Fax #: (512) 380-4253

Polysomnography- Sleep Study Authorization Form

This form should be completed by the person who has a thorough knowledge of the patient's current clinical presentation and his/her treatment history. Please complete ALL parts as clearly and as specifically as possible. Omissions, generalities, and illegibility will result in the form being returned as an incomplete request.

Plan Name ☐ **Seton Care Plus** ☐ **Charity**		☐ **MAP** ☐ **City/County Community Clinic (CCHC)**			
***Request Date:**		***Submitted by (name) :**		***Phone #: and ext:**	
***Return Fax # (include area code if outside Austin):**					
***Patient Name:**					
***DOB:**		***Patient's ID Number:**			
Diagnosis and ICD=10 code:					
***PCP or Requesting Provider Name:**					

☐**REQUEST FOR INITIAL POLYSOMNOGRAM – SPLIT NIGHT (CPAP applied half night if AASM criteria met)**

(complete Section I and II)

SECTION I

□ Patient awakens with a sense of gasping, choking, or suffocations

□ An observer of the patient's sleep reports repeated pauses in breathing, lasting more than 10 seconds, gasping or choking during sleep

□ Awakening of the patient in a state of terror later attributed to the inability to move air through his/her upper airway

□ Patient has to fight off sleep while engaging in activities or actually falls asleep unintentionally in the absence of such apparent causes as use of potentially sedating medications, etc.

SECTION II

Epworth Sleepiness Scale (Required)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze; 1 = slight chance of dozing; 2= moderate chance of dozing; 3- high chance of dozing

Situation	**Chance of dozing (score 0 – 3)**
Sitting and reading	
Watching TV	
Sitting, inactive in public placed (e.g. theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down at rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

☐ **OTHER CLINICAL FINDINGS:**

☐ **REQUEST FOR REPEAT SLEEP STUDY**

☐ Copy of previous sleep study submitted with this request

☐ Indication is following a recent positive first night sleep study, where titration was not performed.

☐ Other indication: Please provide details as to why another sleep study is required:

Requesting Provider Signature and Date:			
SHP AUTHORIZATION NUMBER:		**AUTH DATES:**	
COMMENTS:			