

Sleep Studies (PSG) Adult Clinical Information Fax

To initiate the Consult process for preauthorization, complete this form, attach additional clinical information, and fax to: **888 863-4464**. HealthHelp representatives and physicians are available Monday – Friday, 7 a.m. – 7 p.m., and Saturday, 7a.m. – 4 p.m., Central time. Preauthorization requests may be processed faster online: <https://portal.healthhelp.com/humana>.

Urgent Request is a medically necessary request that requires IMMEDIATE HANDLING due to an unforeseen illness, injury, or condition that could impact the patient's condition. A **phone call to 866-825-1550** is the fastest way to process your urgent request. If you choose to fax your urgent request, please ensure that legible contact information is included for the ordering physician and/or his/her designee stating how they may be reached within the next 24 hours in case additional clinical information is needed to complete the review. An urgent request may be **faxed to: 800-519-9935**.

Date:	Time:	Contact Name:
Contact Email:	Contact Phone Number:	
Member Name:	Member ID Number:	
Member DOB:	Group ID:	
Member Contact Number:		
Ordering Physician Information		
Physician Name:	Ordering Physician NPI:	
Practice Name:	Phone:	
Address:	Fax:	
City:	State:	ZIP:
Email:		
Rendering Facility Information (<input type="checkbox"/> same as Ordering Physician)		
Facility Name:	Facility Type: <input type="checkbox"/> Outpatient	
Facility Tax ID:	<input type="checkbox"/> Ambulatory Surgery Center	
Address:	<input type="checkbox"/> Inpatient; No. of days _____	
City:	State:	ZIP:
Phone:		
Fax:		
Email:		
Procedure Information (include procedure code)		
Date of Procedure (if known):		Procedure:
Date of Procedure (if known):		Procedure:
Date of Procedure (if known):		Procedure:
Clinical Information (pertinent to the request)		
Diagnosis: <input type="checkbox"/> G47.33 Obstructive Sleep Apnea (OSA) <input type="checkbox"/> Other (include diagnosis code):		
Indication (reason for request):		
History of Hypertension (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Height (inches):	
History of Diabetes Mellitus (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Weight (pounds):	
Neck circumference (inches):	BMI:	
Check appropriate boxes:	Not Known or N/A	Strongly Disagree (Never)
	Disagree (<1/wk)	Somewhat Agree (1-2/wk)
	Agree (3-4/wk)	Strongly Agree (5-7/wk)
Patient snores in his/her sleep	<input type="checkbox"/>	<input type="checkbox"/>
Patient gasps, chokes, and/or stops breathing in his/her sleep	<input type="checkbox"/>	<input type="checkbox"/>
Patient snorts in his/her sleep	<input type="checkbox"/>	<input type="checkbox"/>