Humboldt IPA Authorization Request for SLEEP STUDY

Fax Completed Form to 707-442-2047 or Mail to the IPA, 2662 Harris Street, Eureka, CA 95503

Phone: 707 443-4563; we do not accept authorization requests over the phone.

Incomplete request forms will be returned without being processed.

Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

MEMBER INFORMATION

Patient Name:______________________ Gender: M / F Date of Birth:__________

Patient's Address:____
Street City Zip

Phone: __________ Health Plan: HMO: Anthem Blue Cross CaliforniaCare HMO/POS - Blue Shield Cal PERS HMO
PPO: Blue Lake Rancheria - Trinidad Rancheria - North coast Co-op

Subscriber Name: ______________________ Group #:__________

Member's Primary Care Provider:______________________ Subscriber #:__________

REQUESTING PROVIDER INFORMATION	PROPOSED PROVIDER & FACILITY INFORMATION
Name:	Name:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	Phone: Fax:
Contact Name:	Tax ID # (Out of Area Providers only):
Today's Date:	Place of Service:

REQUEST FOR SLEEP STUDY – MEDICAL NECESSITY - ☐CPT 95811 or ☐CPT 95806

1.	**Is this being requested for suspected Obstructive Sleep Apnea? If not, what condition(s) are being evaluated?**	**ICD-10 code:**	**Height:**	**Weight:**

2. **Is this an initial request or a repeat?**
   If repeat, Date of last Sleep Study __________ and attach result

3. **Are there witnessed apnea episodes at night?** *Describe:*

4. **Fitful sleep / awakening episodes?** *Describe:*

5. **Excessive daytime fatigue? (**Epworth Sleepiness scale, etc.) *Describe / document specific instances:*

6. **Loud snoring at night ?** (Do people make comments about it**)** *Describe:*

7. **Hypertension or other cardiovascular disease?** *List:*

8. **Abnormal ENT exam (uvula, soft palate, tonsils, nasal patency)?** *Describe:*

9. **Other pertinent risk factors / symptoms etc.**

• Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed. Providers must verify member eligibility within 5 days of the date of service to ensure coverage..

• Claims for services rendered without required prior authorization may be denied reimbursement. Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.

• The requesting physician or the member may submit authorization appeals to the IPA Medical Management Department.

• This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety Code §1370, and California Evidence Code §1157.

CONFIDENTIAL INFORMATION: This facsimile is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is strictly prohibited. If you have received this message by error, please notify us immediately and destroy the related message. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.