70 N. McClintock, Suite #4
(SW corner McClintock & Chandler Boulevard)
Chandler, AZ 85226
www.metro-nbi.com
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# CERTIFICATE OF MEDICAL NECESSITY

## *Patient Information*

Patient Name: ____________________________________

Address: ________________________________________

City/State/Zip: ____________________________________

DOB: ___/___/___ Social Security#____________________

Telephone:_______________________________________

Other Number: ___________________________________

Ht:__________Wt______________Neck size__________

## *Insurance Information (please send copy of card)*

Company Name: _________________________________

Policy Holders Name: ____________________________

Policy Number: __________________________________

Group # _______________________________________

Telephone: _____________________________________

Employer: ______________________________________

## *PRESCRIPTION INFORMATION*

Sleep Study, Diagnostic    Sleep Study with CPAP Titration    Sleep Study for Re-evaluation    MSLT

## *STATEMENT OF NECESSITY – SYMPTOMOLOGY*

Loud Snoring
Witnessed Apnea
Daytime Somnolence
Obesity
Leg Kicking/Jerking During Sleep
Never Feel Rested

Severe Mood Swings
Decreased Concentration
Frequent use of Bathroom at Night
Doze Off While Driving
Sweat Excessively
Wake Up Coughing / Gagging

Headaches in Morning
Depression
High Blood Pressure
Weight Gain
Irregular Heartbeat
Other

## *DIAGNOSIS / REASON FOR STUDY*

Sleep Apnea
Obstructive Sleep Apnea – Titrate CPAP
Obstructive Sleep Apnea – Re-evaluate to Determine if Current CPAP Level is Still Appropriate
Other____________________________________________________________

Due to the above symptomology and diagnosis. I, the undersigned, certify that the prescribed procedure is reasonable and necessary according to the standards of medical practice in the treatment of this condition.

Physician Signature_____________________________________ Date_______________________

Printed Name__________________________________________ NPI#_______________________

Address______________________________________________ Phone#_____________________

City/State/Zip_________________________________________ Fax#_______________________

**PLEASE RETURN / FAX THIS FORM TO…**

**FAX (480) 753-4709 or Phone: (480) 785-0564    Please Include Patient's H & P**