HEALTHHELP®
A WNS COMPANY

Humana.

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 7am-7pm and Saturday 7am-4pm (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: Member Contact Number:		Group ID:
Ordering Physician Information		
Physician Name:		Ordering Physician NPI:
Practice Name: Address: City: State: ZIP:		Phone: Fax: Email:
Rendering Facility Information (☐ same as Ordering Physician)		
Facility Name: Facility Tax ID:		Facility Type: ☐ Outpatient ☐ Ambulatory Surgery Center ☐ Inpatient; No. of days_____
Address: 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: ☐G47.33 Obstructive Sleep Apnea (OSA) ☐Other (include diagnosis code):

Indication (reason for request):

History of Hypertension (check one): ☐Yes ☐No ☐N/A History of Diabetes Mellitus (check one): ☐Yes ☐ No ☐N/A Neck circumference (inches):	Height (inches): Weight (pounds): 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	☐	☐	☐	☐	☐	☐
Patient gasps, chokes, and/or stops breathing in his/her sleep	☐	☐	☐	☐	☐	☐
Patient snorts in his/her sleep	☐	☐	☐	☐	☐	☐