MEDICARE AND MEDICAL INSURANCE BILLING CHECKLIST

Initial screening form — Date Completed: _____

Physician request for sleep study (Required for Medicare only) — Date Completed: _____

Home Sleep Test / PSG Test Study Report — Date Completed: _____

AHI _____ Bruxism Episodes Index _____ — Date of Report: _____

CPAP Intolerance/Non-Compliance Affidavit — Date Completed: _____

Oral Appliance Rx signed by Physician — Date Completed: _____

Office verified out of network eligibility & benefits for procedures — Date Completed: _____

Treatment & Payment Forms

Exam and Consultation — Date Completed: _____

Sleep Study Report — Date Completed: _____

Informed Consent — Date Completed: _____

Fee for Service Form — Date Completed: _____

Office Payment Agreement — Date Completed: _____

Appliance Delivered Form — Date Completed: _____

Follow-up (if necessary)

Sleep Study (Post Treatment) — Date Completed: _____

Provided by:
AAFE SLEEP
A Collaboration of the AAFE and STATDDS