UNIVERSITY PHYSICIANS BROOKLYN, INC.

University Physicians of Brooklyn, Inc./Sleep Disorders Center

470 Clarkson Avenue – Suite A
Brooklyn, NY 11203

Phone: 718-270-1821
Fax: 718-270-1733

PATIENT INFORMATION

Patient's Name: _____ Sex: ❒ M ❒ F D.O.B. _____/_____/_____

Home Phone: _____ Cell Phone: _____MRN#: _____

Insurance Carrier-ID#: _____ AUTH #: _____

AUTHORIZATION INFO: SERVICE PROVIDER**: SAMIR FAHMY, MD-NPI: 1831183599 –450 CLARKSON AVE, BROOKLYN, NY 11203**

PLEASE ATTACH COPY OF INSURANCE CARD/CLINICAL NOTES/AUTHORIZATION AND FAX TO 718-270-1733

ATTENTION!!! THIS FORM MUST BE SIGNED BY THE REFERRING PHYSICIAN.

Referring physician (print): _____ Office Phone: _____

Physician's Signature: _____ Date: _____ /_____ /_____ Office Fax: _____

RULE OUT OR CONFIRM THE FOLLOWING

❑ **Sleep Apnea-DIAGNOSIS CODE:G47.33**

TYPE OF STUDY REQUESTED

❑ **Consultation**
❑ **Home Sleep Study –CPT CODE: 95806**
❑ **Home Sleep Study connected to PAP– 95806**
❑ **Auto- PAP/CPAP order**
❑ **Mask Fitting/Desensitization - 94660**
❑ **CPAP Management - 94660**

SPECIAL NEEDS OF PATIENT

Medical Diagnosis: _____

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