



SLEEP DISORDERS CENTER
114 Whitwell Street
Quincy, MA 02169
Tel: (617) 376-5710
Fax : (617) 376-2098

**SLEEP DISORDERS CENTER
REFERRAL FORM**

*****THIS FORM MUST BE FILLED OUT COMPLETELY FOR VISIT TO BE SCHEDULED.*****

PATIENT INFORMATION:

Patient Name: _____
Address: _____
Home phone: _____ Cell phone: _____
SS#: _____ DOB: : _____ Sex: _____ Marital Status: _____
Language Spoken: _____ Interpreter Needed: _____ Yes _____ No

INSURANCE : MUST BE COMPLETED. SEE NOTES BELOW FOR TUFTS AND BLUE CROSS MEMBERS.

Health Ins: _____ ID # : _____

OVERNIGHT SLEEP STUDY: ___ Baseline (CPAP if warranted) ___ CPAP* ___ BiPAP*
*requires baseline with diagnosis of sleep apnea

The following insurances require pre-authorization before booking sleep studies.:

Tufts Health Care plans require a pre-authorization. For the latest form, please see
http://www.tuftshealthplan.com/providers/pdf/polysomnogram_form.pdf

Blue Cross Blue Shield requires a pre-authorization. Please see the BCBS website for the appropriate form.

Fallon Community Health plans, incl. Commonwealth Care and Major Medical. See form at
WWW.SLEEPMANAGEMENTSOLUTIONS.COM, or by phone at 1-866-ASK-FCHP

PRE-AUTHORIZATION NUMBER FOR TUFTS/BLUE CROSS/FALLON: _____

Interpretation Physician: _____

REFERRING PHYSICIAN: _____

Phone: _____ Fax: _____

PRIMARY CARE PHYSICIAN: _____

Phone: _____ Fax: _____

APPOINTMENT DATE AND TIME: (To be filled in be Sleep Clinic)

DAY: _____ DATE: _____ TIME: _____