Request for medical documentation – NightBalance

RespirTech®

Patient name: _____ Date of birth: _____

Facility and contact: _____ Date: _____

Thank you for ordering NightBalance. The **INSURANCE REQUIRES THE FOLLOWING SIGNED AND DATED DOCUMENTATION** for approval of positional sleep apnea therapy.

Still needed:

☐	**Documentation within the medical record** supporting the need for positional sleep apnea therapy
☐	**Copy of most recent sleep study**
☐	
☐	
☐	

PLEASE DO NOT DOCUMENT ON THIS FORM

Please return the requested information via MEDICAL RECORD FAX: 833.461.0791.

RespirTech also accepts patient medical records through AllScripts® and other electronic health records (EHRs).
Contact RespirTech_EHR@philips.com with questions.

Name: _____

Phone: _____

Email: _____

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