# Driver's Fee Ticket

**Please submit this form along with other SSD REQUIRED Documents after completed Services** **Fax to: 855.723.3377**

Driver Name _____ DOB _____

_____

Street Address City State Zip

Daytime Phone ( ) - Evening/Cell Phone ( ) -

Email

Employer Name _____ Driver # _____

Date of Visit _____ Date of Study _____ Date of Setup _____

Sleep Center Name: _____ Phone #: _____

Clinician Name: _____ Ordering Physician Name: _____

**Services:**

_____ Follow-up Sleep Medicine Consult
_____ Initial Sleep Medicine Consult
_____ HSAT Testing **Sure ID Band#** _____
_____ HSAT Interpretation
_____ Diagnostic PSG Testing
_____ Split night PSG
_____ Titration PSG
_____ PSG Interpretation (in-lab–all types)
_____ New Patient PAP training and setup

_____ Auto-Pap CPAP purchase
_____ Heated Humidifier purchase
_____ PAP–Auto-Bi-level purchase
_____ PAP–ASV purchase
_____ PAP Nasal Mask
_____ PAP Full Face Mask
_____ Modem Initiation
_____ Chinstrap
_____ DC Converter

| | |
|---|---|
| PAP Device Serial Number | |
| Modem/Wireless Serial Number | |
| Mask Replacement to Lab | |
| Mask #1 Model Number **ONLY** | |
| Mask # 2 Model Number **ONLY** | |

_____ _____
Technician Signature Date

_____ _____
Driver Signature (if provided pap) Date



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