

SLEEP MEDICINE QUESTIONNAIRE

1. Practitioner name: _____
2. Name of facility where you practice: _____
Address: _____
City: _____ Zip: _____ Telephone _____
3. Hours of operation? _____
4. Discharge time for patients? _____
5. Will there be a respiratory therapist on duty to monitor the patients during the sleep study?
 Yes No
Please supply the name of the respiratory therapist and his/her qualifications:

6. What types of monitoring devices are used? Please include types of equipment used for emergency situations:

7. What types of disorders are being treated? _____

8. What is the evaluation process for potential patients? _____

9. What precautionary measures are implemented to prevent the occurrence of sexual misconduct?

10. Please attach documentation regarding accreditation as well as a copy of the consent form for patient treatment.

Signature

Date

Washington State law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Please return to:

Seattle Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
PO Box 91220
Seattle, WA 98111
(206) 343-7300 (800) 962-1399
F (206) 343-7100

Eastern Regional Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
421 W. Riverside Avenue, Suite 1200
Spokane, WA 99201
(509) 456-5868 (800) 962-1398
F (509) 456-0821