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Oral Appliance Referral Form For Medically Diagnosed Obstructive Sleep Apnea

PATIENT INFORMATION

FullName: _____
 Last First M.I. DOB

Address: _____
 Street Address City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Medical Insurance: Medicare? Yes No

Subscriber Name ID Number Subscriber DOB

Employer Name Group Number Policy Number Pt Relationship to Subscriber

Requesting Physician's Name & Practice Name: _____

Practice Phone Practice Fax Physician Email NPI (required)

REASON FOR REFERRAL

Diagnosis Obstructive Sleep Apnea (ICD G47.33) Insomnia due to Sleep Apnea (ICD G47.00)
 Hypersomnia due to Sleep Apnea (ICD G47.10) Apnea/Sleep Related Breathing Disorder, Other, Unspecified (ICD G47.30)

Without Appliance (CPAP or Oral Appliance)
 Respiratory Disturbance Index RDI _____ Apnea Hypopnea Index (AHI) _____
 Lowest Desaturation (SpO2) _____ Percentage or Amount of Time Below 90% _____

Therapies Attempted
 CPAP Intolerant to CPAP Not A Good CPAP Candidate Surgery
 Successful CPAP Pressure Other _____

Comments/Concerns _____

Date of Sleep Test (Include Copy Of Sleep Test) _____

Statement Of Medical Necessity and Prescription

For the above patient, I am prescribing a Mandibular Advancement Device (E0486) used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabrication includes fitting and adjustment. I concur that the recommended therapy is medically necessary, and I prescribe treatment utilizing an FDA approved Mandibular Advancement Device (E0486). I strongly urge you to cover the costs of this therapy. Failure to do so could jeopardize the health of this patient.

Physician Signature

Date