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Oral Appliance Referral Form For Medically Diagnosed Obstructive Sleep Apnea

PATIENT'S INFORMATION

Full Name: _____
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