



Hans Schleicher, DDS
 9099 Katy Fwy, Suite 100
 Houston, TX 77024
 Tel: (713) 828-8587 Fax: (866) 420-8578
SleepHouston.com

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