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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