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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