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Patient Referral

Patient Name: _____ Referring Physician: _____

DOB: _____ NPI: _____

Phone: _____ Phone: _____

Insurance Provider: _____ Email: _____

Insurance Member ID:_____ Office Name: _____

AHI Score

Please provide the AHI or RDI, from the most recent PSG or HST.

3%_____ 4%_____

Diagnosis

- ○ Obstructive Sleep Apnea G47.33
- ○ Sleep Apnea, unspecified G47.30
- ○ Snoring R06.83
- ○ Sleep related bruxism G47.63

Patient History / Comorbid Conditions

- ○ Excessive daytime sleepiness
- ○ Epworth Sleepiness Scale (ESS) > 10
- ○ Fatigue / Daytime sleepiness
- ○ Sleepiness that interferes with daily activity
- ○ Impaired cognition
- ○ Mood disorders
- ○ Insomnia
- ○ Documented hypertension
- ○ Ischemic heart disease
- ○ History of stroke
- ○ Cardiac arrhythmias
- ○ Pulmonary hypertension
- ○ Witnessed Apnea

Statement of Medical Necessity

- ○ The above patient has undergone a sleep study for sleep disordered breathing. The evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an oral appliance is medically necessary.
- ○ The patient could not tolerate CPAP or decided not to use, therefore oral appliance therapy is prescribed.
- ○ CPAP trial was attempted for days _____ , _____ weeks or _____ months.

Physician Prescription

I am prescribing a Mandibular Advancement Device (E0486) for the above named patient who has been diagnosed with Obstructive Sleep Apnea (G47.33). The recommended therapy is medically necessary and I prescribe treatment utilizing an FDA approved Mandibular Advancement Device (E0486). Which is "used to reduce upper airway collapsibility, adjustable or non adjustable, custom fabrication includes fitting and adjustment." Length of need is lifetime. I strongly urge you to cover the cost of this therapy. Failure to do so would jeopardize the health of this patient.

_____

Physicians Signature Date