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Dental Sleep Medicine • Oral Facial Pain • Cosmetic & Implant Dentistry • Orthodontics

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Oral Appliance Therapy Referral Form for Patients with OSA

PATIENT INFORMATION

Full Name: _____
Last First M.I

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Home phone: (____) _____ DOB: _____ E-mail: _____

Requesting Physician's name: _____ E-mail: _____

Insurance Provider: _____ HMO _____ PPO _____ EPO _____ INDEM _____ MCR _____ MCD _____

Policy Number: _____ Group number: _____ Employer: _____

Insured: Self Spouse Child Other Medicare: YES NO

Sleep Study Available: YES NO

REASON FOR REFERRAL (MARK ALL THAT APPLY)

Diagnosis: Obstructive Sleep Apnea (ICD 10-G47.33) Primary Insomnia - Sleep Apnea (F51.01)

Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD 327.20) Atypical facial pain (G50.1)

Hypersomnia - unspecified (G47.10) Insomnia, Unspecified (G47.00)

Rx: Fabricate Custom Oral Appliance

Patient's Readings from diagnostic PSG without CPAP

Respiratory Disturbance Index (RDI) _____ Lowest Desaturation (SpO2) _____

Apnea Hypopnea Index (AHI) _____ Percentage of Time Below 90% _____

Therapies Attempted: CPAP: Intolerant Not a good candidate Surgery: YES NO

Successful CPAP Pressure: _____

Comments/Special Concerns: _____

STATEMENT OF MEDICAL NECESSITY

This above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the need for Oral Appliance as medically necessary. Oral Appliance Therapy (OAT) is used as an alternative to PAP therapy &/or surgery at this time, as the patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

Physician's Signature: _____ Date: _____ Tel: _____

Physician's Name: _____ NPI #: _____