Sleep Better SOUTH CAROLINA

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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**