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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, Unespecified (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 #:_____