

Oral Appliance Referral Form For Medically Diagnosed Obstructive Sleep Apnea

Patient's 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: _____ Physician's Email: _____

Medical Insurance information: _____
 Insurance Provider: HMO PPO POS EPO Indem MCR MCD

Policy Number: _____ Group Number: _____ Employer: _____

Insured: Self Spouse Child Other

Sleep Study Available: Yes _____ No _____ Medicare: Yes No

Reason For Referral (Mark All That Apply)

Diagnosis:

- | | | |
|----------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Obstructive Sleep Apnea (ICD 327.23) | <input type="checkbox"/> Insomnia due to Sleep Apnea (ICD 780.51) | <input type="checkbox"/> Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD 327.20) |
| <input type="checkbox"/> Hypersomnia due to Sleep Apnea (ICD 780.53) | <input type="checkbox"/> Other, Unspecified (ICD 780.57) | |

Without Appliance (CPAP Or Oral Appliance):

Respiratory Disturbance Index (RDI) _____ Lowest Desaturation (SpO2) _____ ODI/DEI _____
 Apnea Hypopnea Index (AHI) _____ Percentage or Amount of Time Below 90% _____

Therapies Attempted:

CPAP: Intolerant Not a good candidate

Surgery: Yes No

Other _____

Successful CPAP Pressure: _____

Comments/ Special Concerns: _____

Statement Of Medical Necessity

This above patient has undergone a sleep study for a sleep related breathing disorder and is being sent for fabrication of an oral appliance. This evaluation confirmed the diagnosis of obstructive sleep apnea and this serves as confirmation that an Oral Appliance is medically necessary. Oral Appliance Therapy is used as an alternative to surgery or CPAP at this time, as this patient could not tolerate CPAP or does not feel they will be able to tolerate CPAP.

Physician's Signature: _____ Date: _____ NPI: _____