DATE:

RespAirSleep
Sleep Apnea Treatment

Please include copies of any recent sleep studies.

FAX BACK TO:

Referring Provider:

Phone:

Fax:

Clinic Name:

Address:

LETTER OF MEDICAL NECESSITY / REFERRAL FORM FOR ORAL APPLIANCE THERAPY

Patient Name:	**DOB:** ____ / ____ / _____
Patient Phone #:	**Age:** ____
Insurance Company: **Group No:** **Account/ID No:** **Insurance Subscriber DOB:** ____ / ____ / _____	**Patient Address:**

Prescribing Physician:

NPI:

Primary Diagnosis: ◯ G47.33 (Obstructive Sleep Apnea) ◯ R06.83 (Snoring)

Secondary Diagnosis (Comorbidities):

Is this patient intolerant of PAP or not a candidate for PAP Therapy:
☐ Intolerant of PAP ☐ Not a candidate for PAP ☐ Other:

Duration of PAP Treatment:
Start Date _____ **End Date** _____ **Still Currently Using** ____ **Yes** ____ **No**

Description of Oral Appliance:

I have attached the following documents needed to proceed with oral appliance treatment:

- ☐ Medical History and Medications
- ☐ Current Progress Notes
- ☐ Diagnostic Sleep Study
- ☐ PAP Trial Study

Physician Signature: **Date:**

Statement of medical necessity: The above patient had a sleep-disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an ORAL APPLIANCE is medically necessary. Currently, Medicare has a code (E0486) with the following descriptor, "ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS" Treatment duration will be at least one year and could be required for the remainder of the patients life. If you should have any questions, please contact the prescribing physician.

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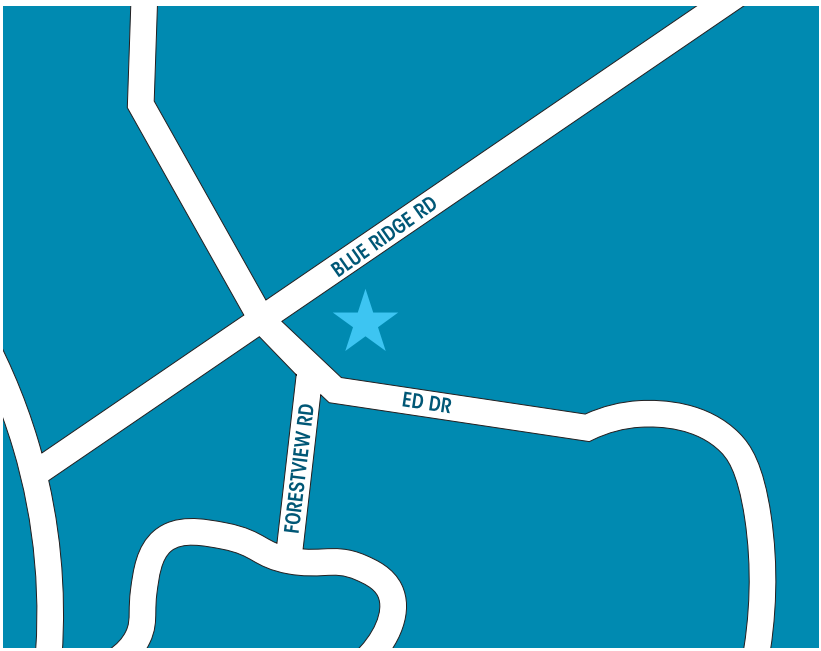

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