Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)

Referring Phyician:_____ Tel:_____

Patient Name:_____ Date of Birth:_____

Patient Address:_____

Patient Telephone:_____

**Please fax copy of patient's medical insurance card with this prescription.*

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

○ Obstructive Sleep Apnea Or ○ Simple Snoring Severity_____

This patient is:

○ Intolerant of C-PAP therapy ○ Not a candidate for C-PAP therapy ○ Choosing oral appliance therapy first

Explanation (if necessary)_____

_____

Notes:_____

_____

Signature of Referring Provider:_____

Date:_____ *As a provider, I deem this therapy to be medically necessary.*

Please fill out this prescription in its entirety.

*Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.

Letter of Medical Necessity for Oral Appliance Therapy

RE:_____

I am writing to inform you that it is medically necessary for the above named patient to be fitted for an oral sleep appliance.

_____was diagnosed with ICD-Code G47.33

_____Mild Obstructive Sleep Apnea

_____Moderate Obstructive Sleep Apnea

_____Severe or Co-Morbidities

Treatment options:

_____The patient has mild or moderate OSA and oral appliance therapy has been advised as first line treatment of choice.

_____The patient, despite having severe OSA, is unable or unwilling to use CPAP

_____The patient is unable to tolerate the CPAP machine

- _____Has failed CPAP use following multiple attempts
- _____CPAP has led to untoward effects making it intolerable
- _____Patient is claustrophobic
- _____Patient failed CPAP use in therapeutic or split night study
- _____Patient has refused CPAP attempts

_____The patient requires the oral appliance and the CPCP machine in combination as a form of treatment

As a result of the diagnosis of his/her obstructive sleep apnea it is medically necessary for him/her to be fitted for an oral sleep appliance.

E0486 Mandibular Advancement Splint for Obstructive Sleep Apnea

It is our preference to have Sleep Better Abingdon insert and monitor the treatment. The staff at Sleep Better Abingdon is appropriately trained and they have demonstrated their expertise in the treatment of our patients that have been referred to Sleep Better Abingdon for oral appliance therapy for patients with mild, moderate and severe sleep apnea as well as other forms of sleep disturbed breathing.

If you need any further information or if I could be of further assistance, please feel free to contact me.

Sincerely,

NPI: