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ORAL APPLIANCE REFERRAL/RX FORM FOR MEDICALLY DIAGNOSED SLEEP APNEA

Please fax form to 303-948-5196

PATIENT INFORMATION

Patient Name: ____ DOB: ______________________

Patient Phone: ____ Email: ______________________________________

Medical Ins Company: _____________________________________ Policy Holder: _________________________________

Insurance ID: ________________________ Group #: ___________Employer ____________________________________

Is a Recent sleep study available?:

☐ Yes (if yes, please fax with this form)

☐ No (Current sleep study results are required for medical ins coverage as well as for comparison post treatment, if not available Dr Page will order one prior to fabrication of sleep appliance)

Referring Physician: __________________________________Physician phone: ____________________________________

Physician fax: _____________________________________ Physician email: _____________________________________

REASON FOR REFERRAL: Mark all that apply

Diagnosis: ☐ **Obstructive Sleep Apnea (ICD 327.23)** ☐Insomnia due to Sleep Apnea (780.51)

☐ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (327.20) ☐Hypersomia due to Sleep Apnea (780.53)

☐ Other, Unspecified (780.57)

RX: ☐ Please Evaluate and Fabricate Custom Oral Appliance for Obstructive Sleep Apnea

MEDICAL INFORMATION

Without CPAP or Other Therapy List the following Stats:

Apnea Hypopnea Index (AHI): _________________________ Lowest Desat (SpO2): ____________________

Respiratory Distress Index (RDI): _______________________ Time Below 90% (%): _____________________

Therapies Attempted:

CPAP: ☐ Intolerate ☐ Not a Good Candidate Surgery: ☐ Yes ☐ No

Medical Comorbities: ____

Other Comments/Concerns: ____

STATEMENT OF MEDICAL NECESSITY: The above patient has under gone a sleep study for a sleep related breathing disorder. This evaluation confirmed that an Oral Appliance is medically necessary. Oral Appliance Therapy (OAT) is used as an alternative to surgery at this time and/or CPAP, as this patient could not tolerate or does not feel he/she will be able to tolerate a CPAP.

Physician Signature: ______________________________________ Date: _______________________