PLEASE COMPLETE & FAX TO: (803) 630- 1529
OR E-MAIL FORM TO: bettersleepbydesign@gmail.com

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Oral Appliance Therapy Referral Form for Medically Diagnosed Obstructive Sleep Apnea

PATIENT'S FULL NAME:____
DATE OF BIRTH:____
ADDRESS:____
*PHONE NUMBER(S) CELL:______________________OTHER:______________________
*EMAIL ADDRESS:____
____

SUBSCRIBER'S NAME: ID NUMBER SUBSCRIBER'S DOB

INSURANCE NAME: ____
POLICY #: ____
GROUP #: ____

REQUESTING PHYSICIAN'S NAME:____
LICENSE: ______________________ NPI:______________________
PHONE NUMBER: ______________________ FAX:______________________
PHYSICIAN'S EMAIL ADDRESS: ______________________*NPI: ______________________
OFFICE NAME:____
OFFICE ADDRESS:____
OFFICE TAX ID:______________________ OFFICE NPI: ______________________

REASON FOR REFERRAL

DIAGNOSIS:

- ❑ Obstructive Sleep Apnea (OSA)-ICD G47.33
- ❑ Insomnia due to Sleep Apnea-ICD G47.00
- ❑ Hypersomnia due to Sleep Apnea- ICD G47.10
- ❑ Snoring-ICD R06.83
- ❑ Apnea/Sleep Related Breathing Disorder, Other, Unspecified- ICDG47.30

WITHOUT APPLIANCE (CPAP OR ORAL APPLIANCE):
Respiratory Disturbance Index (RDI)______________ Apnea Hypopnea Index (AHI) ____________
Lowest Desaturation (SpO2)_____________ Percentage or Amount of Time Below 90% ________________

THERAPIES ATTEMPTED:

- ❑ Intolerant of CPAP Therapy
- ❑ Intolerant to CPAP Therapy
- ❑ Not A Good CPAP Candidate
- ❑ Surgery
- ❑ Successful CPAP Pressure
- ❑ Other:

Date of Sleep Test (Include Copy of Sleep Test):____

STATEMENT OF MEDICAL NECESSITY AND PRESCRIPTION

For the above patient, I am prescribing a Mandibular Advancement Device (E0486) used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabrication includes fitting and adjustment. I concur that the recommended therapy is medically necessary and I prescribe treatment utilizing an appliance chosen by the Patient and Better Sleep By Design as most suitable. I strongly urge you to cover the costs of this therapy. Failure to do so could jeopardize the health of this patient.

Physician's Signature:______________________________________Date:__________________