Oral Appliance:
Medical Prescription and Statement of Medical Necessity

Patient Demographics

Patient Name: **DOB:**

Address: **Gender:**

Patient Insurance

Complete this form & Fax-**up-to-date** patient face sheet **FAX: 855.201.3647**

Choose Diagnosis (ICD-9 code must be to the highest level of specificity) (check all that apply)

327.23 Obstructive Sleep Apnea	780.51 Sleep Apnea (with Insomnia)
327.26 Sleep Related Hypoventilation/Hypoxemia	780.53 Sleep Apnea (with Hypersomnia)
	780.51 Intrinsic Sleep Disorder NOS (Upper Airway Resistance Syndrome)
Other	786.09 Primary Snoring

This Patient has tried	Please construct and Oral Appliance for this Patient. Special Instructions:
CPAP	
Surgery	
Other	

LETTER OF MEDICAL NECESSITY

The above patient has undergone sleep disorder breathing evaluation. This evaluation confirmed the diagnosis as listed above. This evaluation confirmed that an Oral Appliance is medically necessary. Treatment duration will be up to one year and is expected to be required for the remainder of your subscriber's lifetime. Oral Appliance is used as an alternative to surgery and/or CPAP. If you should have questions, please contact the prescribing physician.

In addition to reviewing the Sleep Study the patient has comorbidities marked below, which require the necessary prescribed items above.

Hypertension	Pulmonary hypertension
Excessive daytime sleepiness with a Epworth scale of 10 or greater	Impaired cognition or mood disorders
Sleepy study findings of AHI	Ischemic heart disease or history of stroke
Diabetes	BMI > 28
Witnessed apneas	Habitual snoring
Other: (specify)	

Please sign and date this form. Fax this form, the sleepy study report, insurance card, demographics, prescription & face sheet to 855.201.3647

Physician signature and date