

Oral Appliance: Medical Prescription and Statement of Medical Necessity

Patient Demographics

Patient Name:

DOB:

Address:

Gender:

Patient Insurance		Complete this form & Fax- <u>up-to-date</u> 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)	
327.27 Central Sleep Apnea		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:	
CPAPA			
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

PHONE

FAX

Please fax over: demographics, insurance card, copy of report and face sheet

855.244.7533

855.201.3647