

## Oral Appliance Prescription Form And Letter of Medical Necessity

Patient Last Name: _____	First Name: _____	Date of Birth: _____
Home Phone: _____	Work Phone: _____	SS#: _____
Prescribing Physician's Name: _____		

Diagnosis:	<input type="checkbox"/> 780.57 – Sleep Apnea:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
	<input type="checkbox"/> 780.51 – Sleep apnea (with insomnia):	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
	<input type="checkbox"/> 780.53 – Sleep Apnea (with hypersomnia):	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
	<input type="checkbox"/> 780.52 – Intrinsic sleep disorder NOS (Upper Airway Resistance Syndrome)	
	<input type="checkbox"/> 786.09 – Primary Snoring	
The patient has tried: <input type="checkbox"/> CPAP <input type="checkbox"/> Surgery <input type="checkbox"/> Other _____		
Please construct an <b>Oral Sleep Appliance</b> for this patient.		
Length of Need: Lifetime		
Special Instructions:		
Physician's Signature: _____ Date: _____		

<h3>Statement of Medical Necessity</h3>
<p>The above patient has undergone sleep disordered breathing evaluation. This evaluation confirmed the diagnosis as listed above. This evaluation confirmed that an Oral Sleep Appliance is medically necessary.</p> <p>Treatment duration will be up to one year and is expected to be required for the remainder of your subscriber's life. Oral Sleep Appliance is used as an alternative to surgery and/or CPAP. If you should have questions, please contact the prescribing physician.</p>
Physician's Signature: _____ Date: _____