

**REFERRAL PRESCRIPTION FOR ORAL APPLIANCE THERAPY**

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**ORAL APPLIANCE PRESCRIPTION ORDER FORM**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_/\_\_\_\_/\_\_\_\_**

**Referring Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referring Physician Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sleep Study Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sleep Study Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diagnosis (Please check all that apply)**

\_\_\_Obstructive Sleep Apnea (327.23)\_\_\_ Hypersomnia due to Sleep Apnea (780.53)

\_\_\_ Insomnia due to Sleep Apnea (780.51)\_\_\_ Insomnia as a subjective complaint (307.49)

\_\_\_ Sleep Apnea/Sleep Related Breathing Disorder (i.e.UARS) (327.20)

\_\_\_ Sleep Apnea, Other, Unspecified (780.57)\_\_\_ Narcolepsy (347.00)

\_\_\_ Snoring (786.09)\_\_\_ Dysphagia, Oral Phase (787.21)

\_\_\_ Dysphagia, oropharyngeal phase (787.22)\_\_\_ Other

**Without Appliance With Appliance**

**\_\_\_** Respiratory Disturbance Index (RDI)\_\_\_ Respiratory Disturbance Index (RDI)

\_\_\_ Apnea Hyponea Index (AHI)\_\_\_ Apnea Hypopnea Index (AHI)

\_\_\_ Lowest Desaturation (SpO2)\_\_\_ Lowest Desaturation (SpO2)

\_\_\_ % of Time below 90%\_\_\_ % of Time below 90%

**Treatment Orders (Please check)**

\_\_\_ Mandibular Advancement Device for

\_\_\_Mandibular Advancement Device to be used in treatment of OSAcombination with CPAP

\_\_\_Positional Therapy (positional cushion to prevent supine sleep) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Special Instructions: CPAP Intolerance Affidavit included**

\_\_\_**Medical Justification** -**Patient has tried CPAP and has not tolerated and/or complied with treatment for**

**the following reasons:**

\_\_\_Unable to tolerate mask/straps \_\_\_Unable to tolerate effective CPAP pressure

\_\_\_Unable to tolerate due to Claustrophobia \_\_\_Skin sensitivity

***Physician’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Statement of Medical Necessity**

The above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an ORAL APPLIANCE is medically necessary. Currently, Medicare has a code **(E0486)** with the following descriptor **“Oral Device/Appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated includes fitting and adjustment."** Treatment duration will last a minimum of one year barring the occurrence of other intervening measures, such as surgery, and could be required for the remainder of the subscriber’s life. Oral appliance therapy is used as an alternative to surgery and/or CPAP. Please contact the prescribing physician with any questions. I am recommending oral appliance therapy for the treatment of this patient. I, the undersigned, certify the procedure prescribed above is medically necessary for the treatment of this sleep disorder.

***Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*