Physician Referral Form

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Oral Appliance Therapy Rx & Medical Necessity Form for Medically Diagnosed Obstructive Sleep Apnea

Requesting Physician's Name: _____

Name of Organization/Company/Hospital: _____

Phone: _____ **Fax:** _____

Patient's Name: _____ **DOB (Date of Birth):** _____

Patient's Contact Number: _____

Notes: _____

Diagnosis:

- Obstructive Sleep Apnea – ICD G47.33
- Hypersomnia due to Sleep Apnea – ICD G47.10
- Sleep Apnea/Sleep Related Breathing Disorder, Unspecified – ICD G47.30 (UARS)
- Sleep Apnea, other, Unspecified – ICD G47.30
- Temporomandibular Joint Dysfunction/ Orofacial Pain
- Other

Patient's Diagnostic Sleep Study Results (without CPAP or OA):

- Date of study: _____
- Respiratory Disturbance Index (RDI): _____
- Apnea Hyponea Index (AHI): _____
- Oxygen Desaturation Index (ODI): _____
- Lowest O2 Saturation (SpO2): _____

Statement of Medical Necessity

I am referring the above patient to Dr. Upendra J. Patel, DDS, Inc because I believe it is Medically Necessary for him/her to be fitted for a custom fitted oral appliance, **E0486**

Physician's Signature: _____ **Date:** _____