Van Gordon
SLEEP APNEA CLINIC

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Oral Appliance Prescription Form

And Letter of Medical Necessity

Patient Last Name: ..... First: .....

Date of Birth: _____ Phone#: _____

Prescribing Physician:

Name: Phone#: **Fax#:**

Diagnosis:

G47.33 - Obstructive Sleep apnea	Mild	Moderate	Severe
780.51- Sleep Apnea w/ Insonmia	Mild	Moderate	Severe
780.53 - Sleep Apnea w/ Hyperinsomnia	Mild	Moderate	Severe

The patient has tried: CPAP Surgery Other: _____

Please construct an Oral Sleep Appltance for this patient: E0486 **NU or** Length of need:

lifetime/99 months

Referral: I am referring this patient for oral appliance therapy to: Dr. Van Gordon

Statement of Medical Necessity

The above patient has undergone a sleep disordered breathing evaluation. This evaluation confirmed the diagnosis as listed above. This evaluation confirmed that an Oral Sleep 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 life. Oral Sleep Appliance is used as an alternative to surgery and/or CPAP. If you should have any questions, please contact the prescribing physician.

Physician's Signature: _____ Date: _____