



Physician's Oral Appliance Prescription Form

Patient Name: _____ Referring Physician: _____

Rx:

Please fit and deliver an oral appliance for treatment of Obstructive Sleep Apnea (OSA).

- Please Check all that apply:
- Diagnosis: Obstructive Sleep Apnea (327.23)
 - CPAP / Bi-Level therapy was tried, but the patient was intolerant to it
 - CPAP was never tried.
 - Other: _____

Special instructions if any: _____

Statement of medical necessity (for the insurance company)

The above patient has undergone a sleep study and is diagnosed with obstructive sleep apnea (OSA). Treatment of OSA is a medical necessity. According to the American Academy of Sleep Medicine guidelines oral appliance is a treatment option for OSA.

Ordering Physician's Signature: _____ Date: _____

*****Please fax this form and below information to (650) 696-2417*****

- A copy of the patient's latest sleep study report
- Patient demographics and copy of insurance card

Thank you for your referral

Please call us if you have questions regarding oral appliances or their indications in sleep apnea treatment.

