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Brooklyn, NY 11204
(718) 259-3828



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Bronx, NY 10461
(718) 684-6393

Oral Appliance Referral Form and Statement of Medical Necessity For Medically Diagnosed Obstructive Sleep Apnea

Last Name: _____ First: _____ Sex: M F DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Primary Insurance Carrier: _____ Policy/ID#: _____

Rx: Fabricate Custom Oral Appliance

Diagnosis: Obstructive Sleep Apnea (327.23) Hypersomnia with sleep apnea (780.53)

Sleep Study Available? Yes No

If yes: Date of Study: _____ AHI: _____ RDI: _____ Lowest SaO₂: _____

Statement of Medical Necessity

This above patient had undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis of obstructive sleep apnea/hypopnea Syndrome (Commonly referred to as OSA). Patient with OSA are at high risk for cardiovascular, neuropsychiatric and metabolic consequences if left untreated. These include hypertension, diabetes, arrhythmias, strokes, depression, dementia, just to name a few. Therefore, treatment of this condition is medically necessary and treatment options include the use of oral appliances. This particular patient is a candidate for oral appliance treatment. Oral Appliance Therapy (E0486) is used as an alternative to surgery and or CPAP at this time, as this patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

Physician's Signature: _____ Date: _____

Physician Name: _____ NPI: _____

Phone: _____ Fax: _____