Prescription for Oral Appliance Therapy

To: ☐ Name: _____
Clinic: Snoring & Sleep Apnea Treatment Centers

From: ☐ Name: _____
Clinic: _____

Patient Name: _____ DOB: _____

I am writing to inform you that it is medically necessary for the above patient to be fitted for an oral appliance (Mandibular Advancement Device; HCPCS code E0486/K1027). Quantity: 1, to be used nightly for life.

This Patient:

☐ Was diagnosed with Obstructive Sleep Apnea (ICD-10 G47.33)

☐ Mild ☐ Moderate ☐ Severe

☐ Was not diagnosed with sleep apnea, but due to other disordered breathing, I have suggested an oral appliance for mandibular repositioning.

This Patient:

☐ Is not tolerant of CPAP therapy

☐ Is not a candidate for CPAP therapy

Explanation (if necessary) _____

☐ Requires combination therapy, adding a mandibular advancement device with their CPAP machine

☐ Was advised CPAP was the gold standard, but still requests a mandibular advancement device

Other Comments:

_____

_____

_____

Physician Signature:

Sig: _____ Date: _____