Referral for Oral Appliance Therapy for
Obstructive Sleep Apnea

To: Sleep Better Maryland
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Re: Patient Name:_____ DOB:_____ Date:_____

Fax:
- □ Face-to-Face Physician notes done prior to and post sleep study
- □ Copies of sleep studies – Diagnostic at 3% or 4% and CPAP Titration
- □ Signed Rx & Letter of Medical Necessity (Attached page)

ORDER FORM -- CERTIFICATE OF MEDICAL NECESSITY

Patient Name: _____ DOB: _____

Estimated Length of Need: **99** Months – Lifetime -Nightly use

Diagnosis: **G47.33** Obstructive Sleep Apnea,
other:_____

RX:

__X__ORAL DEVICE/APPLLANCE (E0486) (One) Custom Fabricated, used for the treatment of Obstructive Sleep Apnea to reduce upper airway collapsibility, adjustable, Includes fitting and adjustment.

____ORAL DEVICE/APPLIANCE (E0486) (One) Custom Fabricated, used for the treatment of Upper Airway Resistance Syndrome or Snoring to reduce airway collapsibility, adjustable or non-adjustable, includes fitting and adjustment.

__X__Impressions and Custom preparation (21085) Custom Impressions needed to create the custom appliance E0486

_ X__Mandibular Restorer (21110) Due to the protraction of the mandible as a result of oral appliance therapy for OSA, it is necessary to restore functional muscle length and habitual occlusion. A morning appliance facilitates physiological craniofacial relationships and reduced potential or permanent changes.

I certify that I am the prescribing practitioner Identified on this form and that the medical necessity Information provided is accurate and complete, to the best of my knowledge.

Physician Name_____

Signature_____Date_____

NPI_____