Email: isa@quietdental.com

2102 Bay Ridge Parkway
Brooklyn, NY 11204
718-259-3828

1250 Water Place, Suite 505
Bronx, NY 10461
718-684-6393
Fax-718-684-6396

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

Last Name: _____ First Name: _____ 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 (G47.33) _____ Hypersomnia with sleep apnea (780.53)

Sleep Study Available? _____Yes _____No

If yes: Date of Study _____ AHI: _____ RDI: _____ Lowest SaO_2 : _____

This above patient had undergone a sleep study 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. This included 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's Name Print: _____ NPI: _____

Phone: _____ Fax: _____