Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea

Patient Name: _____ Phone Number: _____

Address: _____ City: _____ St: ___ Zip: _____

Physician: _____ Phone Number: _____

Diagnosis: Mild / Moderate / Severe Obstructive Sleep Apnea – G47.33

Prescription: E0486 – Custom fabricated oral appliance to manage sleep apnea

The above referenced patient is intolerant to, has refused or is not a candidate for CPAP therapy and is being referred for fabrication of an FDA cleared oral appliance to treat his/her sleep apnea. As his/her treating physician, I deem this therapy to be medically necessary.

To Be Filled By:
(dentist name)

Special Instructions:

_____

Physician Name / NPI #:

_____ _____

Physician Signature Date

Sleep Group Solutions 2035 Harding St. #200 Hollywood, FL 33020 855-475-3374