PRESCRIPTION FOR ORAL APPLIANCE THERAPY

Referring Physician:_____

Patient Name:_____ **Patient DOB:**_____
Patient Address: _____
Patient Phone:_____ **Patient Email:**_____
Patient Insurance:_____ **Insurance Phone:**_____
* Please fax a copy of patient's medical insurance card with this prescription

Prescription to be filled by:
Zufhair Hadi, DDS
4200 Morganton Road, Suite 200
Fayetteville, NC 28314
P: (910) 920-3232
F: (910) 491-9731

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

☐ G47.33 Obstructive Sleep Apnea Severity: _____
-or-
☐ R06.83 Snoring

This patient is:
☐ Intolerant of C-PAP therapy ☐ Is not a candidate for C-PAP therapy

Signature of Referring Physician:_____
As a physician, I deem this therapy to be medically necessary
Date:_____
Office name:_____ **Office Tax ID:**_____
Office NPI:_____ **Doctor's NPI #:**_____
Office Address:_____
City:_____**State:**_____**Zip:**_____
Fax #:_____**License #:**_____

*Obstructive Sleep Apnea is a medical condition that tends to become more severe with time, and requires periodic re-evaluation by a qualified physician.

Oral Appliance Therapy (OAT) is less effective in controlling severe sleep apnea than C-PAP, and patients referred for this therapy may need to explore additional options of treatment if the appliance alone is deemed to provide suboptimal management of the sleep apnea. Copies of sleep studies with full report are required by Dr. Hadi for appropriate care and to obtain medical coverage.