Good Night | El Paso
Breathe right, sleep tight

Referral for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA) / TMD

Referring Physician	**Fax.**
Email	**Tel.**
Patient Name	
Email	**Tel.**
Patient Address	

Referral for

☐ **Sleep test.** Patient does not have a formal sleep disordered breathing diagnosis. Based on signs, symptoms, and my recommendations, the patient is interested in sleep testing and treatment options. **Notes:** _____

○ **Obstructive Sleep Apnea.** (G47.33). The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have OSA.
Severity: _____

_____ Patient is interested in Oral appliance therapy for OSA
_____ Currently wears a CPAP but is interested to explore other options.
_____ Has a CPAP but does not use it. Patient is seeking alternatives treatment options.
_____ Intolerant to C-PAP therapy
_____ Not a candidate for C-PAP therapy

Duration (if OAT Referral): _____ Lifetime

○ **Simple Snoring**
○ **Temporomandibular Disorder** (21089)
○ **Myofunctional Therapy** (92597)

Notes.

Signature of referring Physician	NPI#	DD/MM/YYYY Date

Please fax this form. Include patient's demographics, insurance, appointment notes, and sleep study (if patient has one).

As a physician, I deemed this therapy to be medically necessary. I'm a prescribing a custom fabricated oral appliance (EO486, K1027) for the above-named patient who has been diagnosed with sleep apnea (G47.33). I prescribed treatment utilizing and FDA approved Custom Fabricated Oral Appliance. Length of need is lifetime. I strongly urge you to cover the cost of this therapy. Failure to do so would place the patient's health in jeopardy.

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