Physician Referral form for Oral Appliance Therapy

Should the patient be diagnosed with obstructive sleep apnea or snoring and be prescribed oral appliance therapy, please use this form.

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PRESCRIPTION FORM / LETTER OF MEDICAL NECESSITY (LOMN)

FOR ORAL APPLIANCE THERAPY

CODE – E0486 **QUANTITY-1**

Patient Name:	
Patient Phone #:	**DOB: _____/_____/_____ Age: _____**
Prescribing Physician: **(Name and Phone #)**	
Primary Diagnosis: ◯ G47.33 (Obstructive Sleep Apnea) ◯ R06.83 (Snoring)	
Sleep Study: ◯ Yes, it is attached ◯ No, patient is a consultation	
If required by insurance, this patient is intolerant of CPAP or not a candidate for CPAP therapy? ❑ Yes ❑ No	
Duration of Treatment: ◯ Lifetime ◯ Other _____	
Description of Oral Appliance: ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS	
Additional Physician Remarks:	

Physician Signature: _____ **Date:** _____

Statement of medical necessity: The above patient has a sleep-disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an ORAL APPLIANCE is medically necessary.