KEARNEY
COMPREHENSIVE DENTISTRY
TMJ & SLEEP THERAPY

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

Provider Information

Referring Doctor: _____ Referral Date: _____

Doctor's Telephone # _____

Patient Information: *Please email legible copy of insurance card (front & back) with referral.*

Name: _____ DOB: ____/____/____ MALE/FEMALE

Address: _____

Patient's Preferred Phone #: _____ Alternate Phone #: _____

Diagnosis

___ Primary Snoring

___ Obstructive Sleep Apnea- ICD 327.23

___ Hypersomnia due to Sleep Apnea ICD 780.53

___ Insomnia due to Sleep Apnea ICD 780.51

___ Sleep Apnea, Other, Unspecified ICD 780.57

___ Other: _____

___ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified ICD 327.20 (UARS)

Results Without Appliance (CPAP or Oral Appliance)

Respiratory Disturbance Index (RDI): _____ Lowest Desaturation (SPO2): _____

Apnea Hypopnea Index (AHI): _____ % of Time Below 90% _____

Please email copy of PSG Report

Statement of Medical Necessity

The above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis of obstructive sleep apnea or a related condition and that an oral appliance is medically necessary. Oral appliance therapy is used as an alternative to surgery and/or CPAP therapy. This patient has been unable to tolerate CPAP or feels he/she will be unable to tolerate CPAP.

Physician's Signature _____ Date: _____

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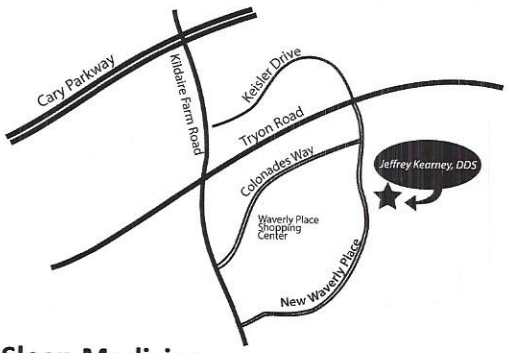

Diplomate American Board of Craniofacial Dental Sleep Medicine