

Oral Appliance Therapy Referral Standard Written Order and Certificate of Medical Necessity

Please fax completed and signed form, pre- and post-sleep study clinical notes, and sleep study reports to: (307) 237-3686



Hilltop Family Dental
3090 Talon Drive, Casper, WY 82604
Adam Milmont, DDS
(307) 237-1801 (office)
(307) 237-3686 (fax)

Patient Name: _____ Date of Birth: _____

Insurance: _____ Phone: _____

Address: _____

Address: _____

Please check ALL that apply:

- Diagnosis:**
- ☐ Obstructive Sleep Apnea (G47.33) ☐ Mild ☐ Moderate ☐ Severe
 - ☐ Upper Airway Resistance Syndrome
 - ☐ Primary Snoring (R06.83)
 - ☐ Central or Complex Sleep Apnea
 - ☐ Other: _____

- Referred for:**
- ☐ Evaluation/Consultation to determine candidacy for Oral Appliance Therapy
 - ☐ Treatment with one Oral Appliance (E0486)
Start Date if different from referral date: _____
 - ☐ Treatment with one Oral Appliance (E0486) to be used with PAP device
Start Date if different from referral date: _____
 - ☐ Other: _____

Statement of Medical Necessity:

- ☐ Referred treatment is medically necessary

Comorbidities:

Establish Medical
Necessity of Tx if OSA is
Mild

- ☐ Excessive daytime sleepiness ☐ Insomnia
- ☐ Impaired cognition ☐ Hypertension
- ☐ Mood disorders ☐ Ischemic Heart Disease
- ☐ History of Stroke

Description

E0486 is an oral device/appliance used to reduce upper airway collapsibility. This includes adjustable or non-adjustable, custom fabricated, fitting and adjustment.

CPAP History

Document Non-Adherence if Applicable

- ☐ Patient is unable to tolerate a positive airway pressure (PAP) device
Date PAP intolerance documented: _____
- ☐ The use of a PAP device is contraindicated in this patient
- ☐ Patient is not required to try CPAP prior to Oral Appliance Therapy
- ☐ Other: _____

Last Sleep Study

- Date: _____
- ☐ Dx ☐ CPAP Titration ☐ Split Night ☐ Other: _____

History of Tx

- ☐ Patient has remained untreated since last sleep study
- ☐ Patient has used or attempted PAP since last sleep study
- ☐ Other: _____

Signature

NPI Number

Date of Referral

Print Name

Email

Phone

*By signing this form, I attest that this is my signature