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Better sleep... For life!

Date:_____

Patient Name: _____

Patient Phone:_____ **DOB:**_____

I am prescribing a Mandibular Advancement Device (E0486 or K1027) for the above-named patient who has been diagnosed with Obstructive Sleep Apnea (G47.33).

Severity: ☐ Mild ☐ Moderate ☐ Severe

Patient declined CPAP or is CPAP intolerant: ☐ Yes ☐ No ***REASON:***

- ☐ Unable to sleep with CPAP equipment in place
- ☐ Develops sinus/throat/ear/lung infections
- ☐ Prior throat surgery made CPAP intolerable
- ☐ Extremely anxious about using CPAP therapy
- ☐ Latex allergy
- ☐ Claustrophobia
- ☐ Refused to attempt CPAP usage
- ☐ Other: _____
- ☐ Mask leaks
- ☐ Unconsciously removes the CPAP apparatus at night
- ☐ CPAP was ineffective in controlling symptoms
- ☐ Cannot find a comfortable mask
- ☐ Pressure of mask and straps causes tissue breakdown
- ☐ Travels and refuses to carry a CPAP machine and hose
- ☐ Job/and or lifestyle prevents this form of therapy (i.e. Active Armed Services/Nat. Guard)
- ☐ Cannot have movement restricted while sleeping
- ☐ Noise from the device disturbs others

Patient has one of the following comorbidities:

- ☐ Hypertension
- ☐ Excessive Daytime Sleepiness
- ☐ Insomnia
- ☐ Mood Disorder
- ☐ Impaired Cognition
- ☐ Ischemic Heart Disease
- ☐ History of Stroke
- ☐ Other: _____

I concur that the recommended therapy is medically necessary, and I now prescribe treatment, utilizing an FDA approved Mandibular Advancement Device. Length of need is lifetime. I strongly urge you to cover the costs of this therapy. Failure to do so would place the patient's health in jeopardy.

Physician Name: _____

Physician NPI: _____

Physician Signature: _____

*Please include with fax patient demographics, insurance, appointment notes, and sleep study (if the patient has one).