SPARK
SLEEP SOLUTIONS
SLEEP APNEA, SNORING & CPAP ALTERNATIVES

Oral Appliance Therapy Rx & Medical Necessity Form for Medically Diagnosed Obstructive Sleep Apnea

Requesting Physician's Name:_____ Phone:_____

Organization:_____ Fax:_____

Patient's Name:_____ DOB:_____ Phone:_____

Notes: _____

_____

Diagnosis:

____ Obstructive Sleep Apnea - ICD G47.33

____ Hypersomnia due to Sleep Apnea - ICD G47.10

____ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified - ICD G47.30 (UARS)

____ Sleep Apnea, Other, Unspecified - ICD G47.30

____ CPAP Intolerance

____ Other _____

Patient has had Diagnostic Sleep Study (without CPAP or OA) :

Date of Study: _____

Respiratory Disturbance Index (RDI): _____

Apnea Hyponea Index (AHI): _____

Lowest Desaturation (SpO2): _____

Statement of Medical Necessity

I am referring the above patient to Dr. Srujal Shah, DDS, DABDSM because I believe it is Medically Necessary for him/her to be fitted for a custom fitted oral appliance (E0486). The above patient had undergone a sleep study and has been diagnosed with obstructive sleep apnea (OSA). According to the American Academy of Sleep Medicine guidelines, oral appliance therapy is a treatment option for OSA. If a CPAP intolerance affidavit is attached, it is because this patient could not tolerate CPAP.

Physician's Signature: _____ Date:_____

Ph: 408-490-0182 • Fax: 408-624-4545
Offices in San Jose, San Ramon, Santa Cruz and Los Gatos
Diplomate of the American Board of Dental Sleep Medicine
Email: info@sparksleep.com Web: www.sparksleep.com