Detailed Physician's Referral and Order Form for Durable Medical Equipment

Patient Name: _____
Patient Address: _____
Patient Phone Number: _____
Date of Birth: _____
Order Date: _____

Referring Provider
Facility Name: _____
Physician's Name: _____
Physician's Address: _____
Physician's Phone: _____
Physician's Fax: _____

Diagnosis: G47.33 Obstructive Sleep Apnea
Prognosis: Good with treatment
Length of Need: 99=lifetime

Item Description: Oral Appliance for Treatment of Obstructive Sleep Apnea (E0486)

Statement of Medical Necessity:
The above patient has undergone polysomnographic evaluation. This evaluation has confirmed the diagnosis of Sleep Apnea/Hypopnea. Oral Appliance therapy is medically necessary and provides effective treatment. I certify that the item(s) is/are medically indicated and in my opinion is/are reasonable and medically necessary with reference to the medical practice for this patient's condition.

Physician's Signature: _____
Physician's NPI: _____
Date: _____

Please provide: Consultation or initial exam report, sleep study and follow-up notes.

Fax to: (203) 776-1714