Should the patient be diagnosed with Obstructive Sleep Apnea or Snoring and be prescribed oral appliance therapy:

Please Fax/Mail us a copy of:

1) Diagnostic Sleep Study with Full Report
2) Completed CPAP Intolerance Form (if required by your insurance)
3) Completed Prescription Form / Letter of Medical Necessity (LOMN)

FAX BACK TO: (413) 732-7401

Center for Dental Sleep Medicine
1795 Main Street, Suite 108
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CENTER FOR Dental Sleep Medicine

PRESCRIPTION FORM / LETTER OF MEDICAL NECESSITY (LOMN)

FOR ORAL APPLIANCE THERAPY

CODE – E0486 QUANTITY – 1

Patient Name:	**DOB:** _____/_____/_____	**Patient Phone #:**
Patient Address:	**Insurance Company:** **Group No:** **Account/ID No:**	
Prescribing Physician:		**NPI:**
Office Address:	**Tel:**	**Fax:**
Primary Diagnosis:	❑ G47.33 (Obstructive Sleep Apnea)	❑ R06.83 (Snoring)
Secondary Diagnosis:		
This patient is:	❑ intolerant of CPAP	❑ is not a candidate for CPAP therapy
Duration of Treatment:		
Description of Oral Appliance:	*ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS*	
Additional Physician Remarks:		
Physician Signature: ______________________________________		**Date:** ____________________

Statement of medical necessity: The above patient has a sleep-disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an ORAL APPLIANCE is medically necessary. Currently, Medicare has a code (E0486) with the following descriptor, "ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS" Treatment duration will be at least one year and could be required for the remainder of the patient's life. If you should have any questions, please contact the prescribing physician.

<u>CPAP Intolerance Form – Please fill this out if required by insurance</u>

I, ______________________________________, have attempted to use CPAP (Continuous Positive Airway Pressure) to manage my sleep-related breathing disorder (OSA-Obstructive Sleep Apnea). However, I find CPAP intolerable to use on a regular basis for the following reason(s):

□ I am unable to sleep with CPAP equipment in place

□ The noise from the device disturbs my sleep or my bed partner's sleep

□ I cannot find a comfortable mask

□ The mask leaks

□ I develop sinus / throat / ear / lung infections

□ I am allergic to materials in the mask and/or head straps

□ Claustrophobia

□ I unconsciously remove the CPA apparatus at night

□ The pressure of the mask and straps cause tissue breakdown

□ My job and/or lifestyle prevent this form of therapy (e.g. Active Army / National Guard Duty)

□ Prior throat surgery made CPAP intolerable

□ Refused to attempt CPAP usage

□ CPAP was ineffective in controlling my symptoms

□ OTHER: ____

____

Because of my non-compliance/inability to use CPAP, and my need to manage the signs and symptoms of OSA, I wish to pursue an alternative method of treatment: Oral Appliance Therapy (OAT) using a custom-fit mandibular advancement device.

Patient Signature: ___________________________________ Date:___________________

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