Prescription for Oral Appliance Therapy

Provider Authorization & Letter of Medical Necessity

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PATIENT NAME:_____ **DOB:**_____

It is medically necessary for the patient to be fitted for a custom oral appliance *E0486* (OA, OAT, MAS, and MAD) for the treatment and management of obstructive sleep apnea (OSA), sleep disordered breathing, TMJ, and/or bruxism. Supplier will work with the patient to find the proper custom appliance, will help monitor its effectiveness, and work with the patient to achieve long term compliance.

- ☐ **The above patient was diagnosed with obstructive sleep apnea (OSA- G47.33)**
- ☐ **The patient was supplied a CPAP machine but is unable to tolerate the CPAP machine, and/or refuses to wear a CPAP machine**
- ☐ **The patient requires combination therapy, adding an oral appliance to their CPAP machine**
- ☐ **The above patient was not diagnosed with sleep apnea, but due to sleep disordered breathing /TMJ/bruxism, I have suggested an oral appliance for mandibular repositioning.**
- ☐ **Length of Need: Lifetime, 99**
- ☐ **Other Diagnoses/Comments:**_____

HEALTHCARE PROVIDER INFORMATION:

Physician Name:_____ **NPI:**_____

Address:_____

City: _____ **State:**_____ **Zip:**_____

Phone:_____ **Fax:**_____

_____ _____

Provider Signature **Date**

PLEASE FAX TO: (888) 390-0424

THANK YOU!