RESTORATIVE SLEEP SOLUTIONS

BETTER SLEEP FOR A BETTER LIFE

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)*

Referring Physician: _____ Tel: _____

Patient Name: _____

Patient Address:_____

Patient Telephone: _____

Prescription to be filled by:

**Please fax a copy of patient's medical insurance card with this prescription*

Restorative Sleep Solutions

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The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

☐ **Obstructive Sleep Apnea G47.33** **Severity: _____**

-or- **Length of Treatment: Lifetime**

☐ **Simple Snoring**

This patient is:

☐ **Intolerant of C-PAP Therapy** ☐ **Is not a candidate for C-PAP Therapy**

Explanation (if necessary) _____

_____

This patient is being referred for E0486 Mandibular Advancement Device Therapy with:

☐ **The appliance chosen by Dr. Jesson from Restorative Sleep Solutions and the patient, as most suitable**

Signature of Referring Physician:_____

Date: _____ Physician NPI #: _____

As a physician, I deem this therapy to be medically necessary.

*Please fill out this prescription in its entirety. *Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.*