DENTAL SLEEP CENTER of Hawaii

FAX to: 808-769-5023

Oral Appliance Referral Form & Statement of Medical Necessity for Medically Diagnosed Obstructive Sleep Apnea

Requesting physician's Name:_____ Organization:_____

NPI#:_____ Phone:_____ Fax:_____

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

Diagnosis:

__ Obstructive Sleep Apnea - ICD 327.23
__ Hypersomnia due to Sleep Apnea - ICD 780.53
__ Insomnia due to Sleep Apnea - ICD 780.51
__ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified - ICD 327.20 (UARS)
__ Sleep Apnea, Other, Unspecified - ICD 780.57
__ Other: _____

_____ **Without Appliance (CPAP/OA)** or _____ **SEE ATTACHED PSG**
Respiratory Disturbance Index (RDI): _____
Apnea Hyponea Index (AHI): _____
Lowest Desaturation (SpO2): _____
% of Time below 90%: _____

Statement of Medical Necessity

This above patient had undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis of obstructive sleep apnea/Hypopnea Syndrome (Commonly referred to as OSA). Patient with OSA are at high risk for cardiovascular, neuropsychiatric and metabolic consequences if left untreated. These include hypertension, diabetes, arrhythmias, strokes, depression, dementia, just to name a few. Therefore, treatment of this condition is medically necessary and treatment options include the use of oral appliances. This particular patient is a candidate for oral appliance treatment. Oral Appliance Therapy (E0486) is used as an alternative to surgery and or CPAP at this time, as this patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

Physician's Signature: _____ Date:_____

Dental Sleep Center of Hawaii
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