Referring Physicians Form

DENTAL ASSOCIATES
SLEEP SOLUTIONS

Date: _____

LETTER OF MEDICAL NECESSITY

RE: Obstructive Sleep Apnea and Oral Appliance Therapy

Ordering Physician: _____

Physician's Address: _____

Physician's Phone: _____

Physician's FAX: _____

Patient: _____D.O.B:_____

To Whom it May Concern,

_____ is under my care for Obstructive Sleep Apnea (G47.33), a diagnosis confirmed by a sleep study dated_____.
The patient scored an AHI of _____.
The patient is unable to tolerate CPAP effectively.
The above named patient was diagnosed as indicated. Treatment of this condition is thus ordered as a medical necessity.

I believe the patient is a good candidate for an Oral Appliance.

Oral Appliance Type: Custom fabricated mandibular advancement device (E0486)

I have referred the patient to Dr. Ofer M. Doron, Diplomate – ABDSM.

Dr. Doron is a local dentist who has specialized training in the treatment of patients with OSA with the use of oral appliance therapies. The device that I have prescribed is for the treatment of the patient's OSA, a medical condition, and NOT for any dental disorder.

Rx Oral Appliance for Obstructive Sleep Apnea Syndrome (E0486)

DEA Reg. No._____

NPI No._____ _____
Physician's Signature

Date of Order: _____

Please fax this completed form to 860-677-5839 or email to doronstaff@dasmile.com