Blum & Isakov
Dental

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Obstructive Sleep Apnea Oral Appliance

Patient Name:_____Phone:_____D.O.B._____/_____/_____

Address:_____City:_____St:_____Zip:_____

Primary Care Provider Please Complete Below Information

Diagnosis of OSA? (G47.33): Yes ☐ No ☐

Rx: E0486- Custom fabricated oral appliance to manage sleep apnea Yes ☐ No ☐

The above referenced patient is intolerant to, has refused or is not a candidate for CPAP therapy and is being referred for fabrication of an FDA cleared oral appliance to treat his/her sleep apnea. As his/her treating physician, I deem this therapy to be medically necessary.

Please send Baseline Sleep Study, Insurance Card and Office Visit Note

Reason for referral (please check all that apply):

- ☐ Suspected Sleep Apnea
- ☐ CPAP non-compliant or non-tolerant
- ☐ Desires combination of CPAP and Oral Appliance Therapy
- ☐ Snoring
- ☐ Prefers CPAP Alternative
- ☐ Other:_____

Referring Physician Name:_____Phone:_____

Referring Physician Signature:_____Date:____/____/_____

NPI:_____