

Prescription for Durable Medical Equipment

Certificate of Medical Necessity and Prescription for Oral Appliance Therapy

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Phone 281-557-7747 Fax 409-938-8080

First: _____ Last: _____ Sex: _____ DOB: _____
Address: _____ Social Security: _____
City, St, ZIP: _____ Primary Insurance: _____
Home Phone: _____ Primary Insurance ID#: _____
Work Phone: _____ Secondary Ins Co: _____
Cell Phone: _____ Secondary Ins ID#: _____

Medical Necessity

Check all conditions that apply to patients' condition

- Obstructive Sleep Apnea (G47.33)
- Excessive Daytime Sleepiness (G47.10)
- Periodic Limb Movement (G47.61)
- Ischemic Heart Disease (I25.9)
- Hypertension (I10) COPD (J44.9)
- Snoring (R06.83) Heart Failure (I50.9)

Supporting Documentation

- Clinical Notes (Pre-Treatment Evaluation)
- Diagnostic Sleep Test (attached) -and/or-
- PSG or HSAT results:

Date of Diagnostic Test: _____ AHI: _____ RDI: _____ ODI: _____ Lowest O2: _____ % time under 90%: _____

Oral Appliance Therapy

- Custom Mandibular Advancement Device (MAD) (E0486)
 - Medicare Coverage
- Custom MAD with Nasal Pillows attachment
- Custom jaw stabilization device (no advancement) (A7034/A7035)
- Custom nose/mouth mask with intra-oral stabilization

I request and authorize Dr. Brent Patterson, DDS and Sound Asleep Solutions to obtain my medical records. A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.

Patient Signature

Date

Statement of Medical Necessity and Prescription for Oral Appliance Therapy

I am prescribing an FDA approved Mandibular Advancement Device (E0486) (quantity 1) for Obstructive Sleep Apnea (G47.33). This therapy is required to effectively manage the patients' medical condition.

The above referenced patient has an absolute Medical Necessity for the item(s) listed above. I certify that the above prescribed items is/are medically indicated and in my opinion is/are reasonable and medically necessary with reference to the standard of medical practice for this patient's condition. The duration of the appliance/supplies will be lifetime unless otherwise indicated here: _____.

Physician Name: _____ NPI # _____ Office Phone: _____

Physicians Signature: _____ Date: _____

Sound Asleep Solutions is a Durable Medical Equipment company that provides custom oral appliance therapy.

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