Prescription for Durable Medical Equipment

Certificate of Medical Necessity and Discontinuation of PAP Therapy

ORAL APPLIANCE THERAPY FOR NON-COMPLIANCE OR INTOLERANCE TO PAP THERAPY

Phone 281-557-7747 Fax 409-938-8080 info@soundasleepsolutions.com

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 (125.9)

☐ Hypertension (110) ☐ COPD (J44.9)

☐ Snoring (R06.83) ☐ Heart Failure (150.9)

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, Discontinuation of PAP therapy notice and Oral Appliance Therapy Prescription

Due to the above referenced patients inability to continue with the previously prescribed Positive Airway Pressure (PAP) Therapy for their currently diagnosed Obstructive Sleep Apnea**, I am discontinuing the prescription for PAP therapy (E0601) and now prescribing an FDA approved Mandibular Advancement Device (E0486) (quantity 1) for Obstructive Sleep Apnea (G47.33).**

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.

League City (NPI 1124473269), 3891 E League City Pkwy, 77573 (office: 282-557-7747)

Texas City (NPI 1235657206), 7111 Med. Center Dr. #105, 77591 (office: 409-938-1700)