Prescription for Durable Medical Equipment

Certificate of Medical Necessity and Prescription for Combination PAP and Oral Appliance 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 and Prescription for Oral Appliance Therapy in conjunction with PAP Therapy

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

League City (NPI 1124473269), 3891 E League City Pkwy, 77573 (office: 281-557-7747)

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