Dental Solutions for Medical Problems

REFERRAL REQUEST FORM

Phone: 888-340-4525

FAX: 866-647-4367

www.nomoresnoring.com

PLEASE PRINT

PATIENT'S NAME: (LAST)_____(FIRST)_____	**PATIENT'S PHONE** PRIMARY ( ) _____ SECONDARY ( ) _____
DOB: / /	Gender: ☐ **M**ale ☐ **F**emale
SERVICE REQUESTED: ☐ **ORAL APPLIANCE (OSA/SNORING)** ☐ **TMJ EVALUATION / TREATMENT** ☐ **BRUXISM**	**ICD-9 CODES** _____ _____ _____

PLEASE FAX THE FOLLOWING REQUIRED DOCUMENTS:

☐ DEMOGRAPHICS
☐ LETTER OF MEDICAL NECESSITY / PRESCRIPTION
☐ INSURANCE INFORMATION (COPY OF INSURANCE CARD)
☐ DIAGNOSTIC SLEEP STUDY (BASELINE)

NOTES:

REFERRING PHYSICIAN:

_____ _____

PLEASE PRINT PLEASE SIGN

Phone: _____-_____-_____ Fax: -_____-_____

PCP Name :

Phone: _____-_____- Fax: -_____-_____

CONTACT NAME AT REFERRING PHYSICIAN'S OFFICE:

_____ Phone: ( ) _____

LOCATIONS

Citrus Heights | **Sacramento** | **Vacaville** | **San Rafael** | **San Francisco** | **San Mateo** | **San Jose**

Members of the AADSM, AASM, ACSDD, ICCMO
Diplomate of the *AADSM and ACSDD*

Letter of Medical Necessity

Re: _____
(Patient Name)

Date of Birth: _____

Based on a sleep study performed on _____, my patient was diagnosed with Obstructive Sleep Apnea (OSA- 327.23). The study indicates:

Apnea/Hypopnea Index (AHI) of _____
Respiratory Disturbance Index (RDI) of _____

Various treatment options were presented and discussed with the patient. At this time, the patient:

- ☐ Is not a candidate for CPAP/Surgery
- ☐ Wants Oral Appliance as their first choice of treatment
- ☐ Failed other available treatment options
- ☐ Other:

I believe that this patient is an excellent candidate for Oral Appliance Therapy. I have referred him/her to Dental Medicine Providers, who specialize in the treatment of OSA. The Mandibular Advancement Device which I have prescribed is for the treatment of the patient's Obstructive Sleep Apnea, a medical condition, and is **NOT** for any dental disorder. (HCPCS code E0486)

As you may be aware, Obstructive Sleep Apnea requires a treatment that the patient can use long term. If left untreated, the patient is at risk for cardiovascular incidents, such as heart attack, stroke, arrhythmias, as well as diabetes, depression, memory issues, etc.

_____
Physician's Signature

NPI # _____

Date: ____/____/____

DENTAL MEDICINE PROVIDERS

INNA SHTURMAN, DDS

OLGA BECKINGER, DDS

CLARA MICHELSON, DDS

LUBA KISILYUK, DDS

www.nomoresnoring.com www.painpuzzle.com

PRESCRIPTION FOR ORAL APPLIANCE THERAPY

Please complete and attach Prescription for Oral Appliance Therapy on a standard Prescription Pad and place in this box. Fax it back to our office with the LoMN at 866-647-4367