

# Oral Appliance Therapy Referral Standard Written Order and Certificate of Medical Necessity

Please fax completed and signed form, pre- and post-sleep study clinical notes, and sleep study reports to: (833) 255-1294



**NORTH CAROLINA**  
**Sleep Solutions**

## WILLIAM GROSS, DDS

- Treating Sleep apnea patients with oral appliance therapy for over 30 years
- In-Network with Aetna, BCBS, Cigna, Humana, TriCare, & United Healthcare
- Medicare credentialed

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

### Please check ALL that apply:

- Diagnosis:**
- Obstructive Sleep Apnea (G47.33)     Mild     Moderate     Severe
- Upper Airway Resistance Syndrome
- Primary Snoring (R06.83)
- Central or Complex Sleep Apnea
- Other: \_\_\_\_\_

- Referred for:**
- Evaluation/Consultation to determine candidacy for Oral Appliance Therapy
- Treatment with one Oral Appliance (E0486)  
Start Date if different from referral date: \_\_\_\_\_
- Treatment with one Oral Appliance (E0486) to be used with PAP device  
Start Date if different from referral date: \_\_\_\_\_
- Other: \_\_\_\_\_

### Statement of Medical Necessity:

- Referred treatment is medically necessary

### Comorbidities:

Establish Medical Necessity of Tx if OSA is Mild

- Excessive daytime sleepiness     Insomnia
- Impaired cognition     Hypertension
- Mood disorders     Ischemic Heart Disease
- History of Stroke

#### Description

**E0486** is an oral device/appliance used to reduce upper airway collapsibility. This includes adjustable or non-adjustable, custom fabricated, fitting and adjustment.

### CPAP History

Document Non-Adherence if Applicable

- Patient is unable to tolerate a positive airway pressure (PAP) device  
Date PAP intolerance documented: \_\_\_\_\_
- The use of a PAP device is contraindicated in this patient
- Patient is not required to try CPAP prior to Oral Appliance Therapy
- Other: \_\_\_\_\_

### Last Sleep Study

- Date: \_\_\_\_\_
- Dx     CPAP Titration     Split Night     Other: \_\_\_\_\_

### History of Tx

- Patient has remained untreated since last sleep study
- Patient has used or attempted PAP since last sleep study
- Other: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
NPI Number

\_\_\_\_\_  
Date of Referral

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Email

\_\_\_\_\_  
Phone