CHATTANOOGA SLEEP ASSOCIATES
AT LUNN DENTISTRY
THE CARE YOU DESERVE, THE EXPERIENCE YOU TRUST

Physician: Oral Appliance Referral Form For Medically Diagnosed Obstructive Sleep Apnea

Patient's Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ DOB: _____ E-mail: _____

Requesting Physician: _____
Physician's Name *Physician's E-mail*

Medical Insurance Information:
Insurance Provider:

☐ HMO ☐ PPO ☐ POS ☐ EPO ☐ Indem ☐ MCR ☐ MCD

_____
Policy Number *Group Number* *Employer*

Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Sleep Study Available: ☐ Yes ☐ No Medicare: ☐ Yes ☐ No

Reason For Referral (Mark All That Apply)

Diagnosis:

☐ Obstructive Sleep Apnea (ICD 327.23)
☐ Hypersomnia due to Sleep Apnea (ICD 780.53)
☐ Insomnia due to Sleep Apnea (ICD 780.51)
☐ Other, Unspecified (ICD 780.57)
☐ Sleep Apnea / Sleep Related Breathing Disorder, Unspecified (ICD 327.20)
☐ Rx for E0486

Without Appliance (PAP Or Oral Appliance):

Respiratory Disturbance Index (RDI) _____ Lowest Desaturation (SpO2) _____

Apnea Hypopnea Index (AHI) _____ Percentage or Amount of Time Below 90% _____

Therapies Attempted:

PAP: ☐ Intolerant ☐ Not a good candidate Surgery: ☐ Yes ☐ No

Other: _____ Successful PAP Pressure: _____

Comments / Special Concerns: _____

Statement Of Medical Necessity

This above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an Oral Appliance is medically necessary. Oral Appliance Therapy is used as an alternative to surgery at this time and or PAP, as this patient could not tolerate PAP or does not feel he/she will be able to tolerate PAP.

Physician's Signature: _____ Date: _____

Thank you for your referral. If you have any questions please contact us at:

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