PRESCRIPTION FOR ORAL APPLIANCE THERAPY

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NS3 NorCal Snore and Sleep Solutions Inc.
Better Sleep, Better Life

Referred By: _____ Date: _____

Introducing: _____ DOB: _____

Address: _____ Phone: _____

Email: _____ INS: _____

Policy #: _____ Group: _____

(PLEASE FAX A COPY OF MEDICAL INSURANCE CARD WITH RX)

Most Recent HST/PSG reports, clinical notes ☐ FAXED ☐ EMAILED ☐ UPLOADED

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

☐ G47.33 Obstructive Sleep Apnea ☐ R06.83 Snoring

This Patient is:

☐ Intolerant to CPAP ☐ is not a candidate for CPAP ☐ Declined CPAP

The patient is being sent for E0486 Mandibular Advancement Splint therapy evaluation and treatment by Dr Shirisha Krishnamurthy:

Signature of Referring Physician: _____
(As a physician, I deem this therapy to be medically necessary)

Office Name: _____

Tax ID: _____ NPI: _____

Office address: _____

City: _____ State: _____ Zip: _____

Obstructive Sleep Apnea is a medical condition that tends to become more severe with time, and requires periodic re-evaluation by a qualified physician.

Oral Appliance Therapy (OAT) is less effective in controlling severe sleep apnea than CPAP, and patient referred for this therapy may need to explore additional options of treatment if the appliance alone is deemed to provide suboptimal management of the sleep apnea. Copies of sleep studies with full report are required by Dr Shirisha Krishnamurthy for appropriate care and to obtain medical coverage.