Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea & Verification of Medical Necessity Form

In order to facilitate prompt insurance reimbursement for our mutual patient, I ask that you please sign and return this form to the office address listed at the bottom of this document. Once the sleep apnea appliance is in place a follow-up study will be administered to validate the efficacy of treatment. Results will be forwarded to you.

TREATING PHYSICIAN INFORMATION

PHYSICIAN NAME: _____ **PHONE#:** _____

OFFICE ADDRESS: _____

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE#:** _____

PATIENT ADDRESS: _____

PRESCRIPTION INFORMATION

PRESCRIPTION TO BE FILLED BY: *Stephen J. Gershberg, DMD, PC - Main Line Snoring Solutions*

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

OBSTRUCTIVE SLEEP APNEA, with severity of... ☐ ***Mild*** ☐ ***Moderate*** ☐ ***Moderate to Severe***

This patient is... ☐ ***Intolerant of CPAP Therapy*** ☐ ***Is not a candidate for CPAP Therapy***

Explanation (if necessary): _____

This patient is being sent for Sleep Apnea Therapy utilizing an FDA-Approved Oral Sleep Apnea Appliance.

MEDICAL NECESSITY VERIFICATION & PRESCRIPTION AUTHORIZATION

As the patient's treating physician, I deem this therapy to be MEDICALLY NECESSARY.

PHYSICIAN'S NPI#: _____ **PHYSICIAN'S LICENSE#:** _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

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