Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)

P: 734-219-0343
F: 734-219-0345

Design 4 Sleep

Referring Physician:_____ Phone_____
Patient Name:_____
Patient Address:_____
Patient Phone:_____
*Please Fax a copy of Patient's medical insurance card with this prescription.

Prescription to be filled by Design 4 Sleep

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 Severity: _____
-or- Length of Treatment: Lifetime
◯ Snoring without Apnea

This Patient is:

◯ Intolerant of C-PAP therapy
◯ Is not a candidate for C-PAP therapy
Explination:_____

The patient is being referred for **E0486** Mandibular Advancement Device therapy with:

◯ The device chosen by Design 4 Sleep and the patient, as most suitable

Signature of Referring Physician:_____
Date:_____ NPI#:_____

As a physician, I deem this therapy to be medically necessary.

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