REstore
TMJ & Sleep Therapy

Rx For Oral Appliance Therapy

PATIENT'S NAME:_____ DATE:_____

Phone: _____ DOB:_____ Female ☐ Male ☐

PHYSICIAN NAME: _____

Phone: _____

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

- ☐ Obstructive Sleep Apnea (G47.33)
- ☐ Sleep Apnea/Sleep Related Breathing Disorder (UARS) (G47.3)
- ☐ Sleep Apnea, Other, Unspecified Severity _____ (G47.30)
- ☐ Snoring (R06.83)
- ☐ Hypersomnia due to Sleep Apnea (G47.14)
- ☐ Other _____

This patient is a candidate for:

- ☐ **Mandibular Advancement Device**
- ☐ **Requires combination therapy, adding a Mandibular Advancement Device with CPAP Therapy**
- ☐ **Custom Mask with CPAP Therapy**

Statement of Medical Necessity

The 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. Currently, Medicare has a code (E0486) with the following descriptor **"Oral Device/Appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated includes fitting and adjustment."** Treatment duration will last a minimum of one year barring the occurrence of other intervening measures, such as surgery, and could be required for the remainder of the subscriber's life. Oral appliance therapy is used as an alternative to surgery and/or CPAP. Please contact the prescribing physician with any questions. I am recommending oral appliance therapy for the treatment of this patient. I, the undersigned, certify the procedure prescribed above is medically necessary for the treatment of this sleep disorder.

Physician Signature: _____ Date: _____

FAX this form to: 281-296-6887

Prescription to be filled by: **Katherine S. Phillips, DDS**
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