Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea

Patient Name: _____**Patient DOB:** _____

Patient Address: _____

Patient Phone: _____**Patient Email:**_____

Patient Insurance:_____**Insurance Phone**: _____
*Please fax a copy of patient's medical insurance card with this prescription

Prescription to be filled by:
Bracken Sorensen, DMD
QUALITY SLEEP NORTHWEST, LLC
181 E 1st Ave.
Colville, WA 99114
PH: (509) 685-7445
Fax: (509) 873-7196

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 Severity: _____
(Please included recent sleep study)

This patient is:

☐ Intolerant of C-PAP therapy ☐ Use for Travel ☐ Is not a candidate for C-PAP therapy

The patient is being sent for E0486 Mandibular Advancement Splint therapy with:

☐ The appliance chosen by Dr. Bracken Sorensen and the patient, as most suitable

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

Date: _____

Office Name: _____ **Office Tax ID**: _____

Office NPI: _____ **Doctor's NPI #:**_____ _____

Office Address: _____

City: _____ **State:** _____ **Zip**: _____

Fax#:_____ **License #:** _____

*Obstructive Sleep Apena 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 sever sleep apnea than C-PAP, 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. Lauck for appropriate care and to obtain medical coverage.