Physician Written Order for Oral Appliance Therapy in the Treatment of OSA

Date: _____

Ordering Physician:
Name: _____ NPI: _____
Address: _____
_____, OH _____
Phone: _____ *Fax:* _____

Referral To:
Shelley D. Shults, RN, DDS, D.ABDSM NPI: 1619034204
Powell Dental Group
39 Clairedan Drive
Powell, OH 43065
Phone: 614.396.9310 *Fax:* 614.436.6055

Patient Name: _____ DOB: _____
M or F MRN: _____
Primary Medical Insurance: _____ Group#: _____
Policy Holder Name: _____ Policy Holder DOB: _____
ID#: _____

Diagnostic Test Date: _____ Type: PSG / OCST
Dx AHI: _____ REM AHI: _____ RDI: _____ Nadir: _____ ODI: _____ CI: _____
Circle One: CPAP Failed / CPAP Refused / Combo Therapy / Other: _____
Notes: _____

ICD 10 Code(s):
G47.33 Obstructive Sleep Apnea, Adult / Pediatric Circle: Mild / Moderate / Severe
Other Codes: _____ - _____
_____ - _____

HCPCS Code:
E0486 ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT

A custom-fabricated Oral Appliance for OSA is defined as one that is individually made for a specific patient (no other patient would be able to use this item) starting with basic materials. It involves substantial work to produce, usually by a specialized lab. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending or making other modifications to a substantially prefabricated item. The appliance must be adjustable in no greater than .5mm increments in protrusive repositioning and must be able to retrude by .5mm from initial fabricated protrusive set position. It must be FDA approved for the treatment of OSA and meet with AADSM parameters. It must be fit by a trained and licensed dentist.

Please fabricate the following oral appliance:
_____ SomnoDent Dorsal Fin Classic or Flex _____ EMA
_____ SomnoDent Herbst / Advance Classic or Flex _____ Other: _____
_____ SomnoDent Edentulous
Material Allergens: _____

The above patient was diagnosed as indicated. Treatment of this condition is thus ordered as a medical necessity and to be fabricated, fitted and calibrated by a dental sleep medicine physician dentist. Efficacy will be determined by a final sleep study by the medical physician.

Physicians Signature: _____ Date: _____
Dental Sleep Medicine Physician Signature: _____ Date: _____