Sleep Wellness Matters
Sleep Well... Live Well...

Physician Order for Oral Appliance for OSA

Patient's Name: _____
Phone Number: _____
Date of Birth: _____
AHI: _____

Diagnosis: Obstructive Sleep Apnea Adult Pediatric G47.33

Oral Appliance Type:

- ☐ HST 95806
- ☐ HST 95800
- ☐ E0486 (Oral Appliance)
- ☐ 76102 (Radiological Exam

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

The above patient has had a confirmed diagnosis of Obstructive Sleep Apnea and is opting for a custom fabricated oral appliance to treat on a nightly basis for a long-term or lifetime duration.

Signature: _____
NPI: _____
Date: _____
License Number: _____
Health Care Provider Name: _____

- ☐ MD
- ☐ DO
- ☐ PA/NP

Address: _____
Phone Number: _____
Fax Number: _____

Please fax the slip, initial sleep study and reporting prior to consultation

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