NorthShore
DENTAL HEALTH

ORAL APPLIANCE PRESCRIPTION FORM *and letter of medical necessity*

PATIENT NAME: LAST FIRST	DATE OF BIRTH	SS#
PRESCRIBING PHYSICIAN'S NAME	HOME PHONE NUMBER	WORK PHONE NUMBER

Diagnosis: # 780.53 LENGTH OF NEED: LIFETIME

Apnea/Hypopnea Index: _____ Lowest Oxygen Saturation: _____

Special Instructions: _____

_____

PHYSICIAN'S SIGNATURE	DATE

STATEMENT OF MEDICAL NECESSITY

The above patient has undergone sleep disorder evaluation. This evaluation confirmed the diagnosis of **apnea**. This evaluation confirmed that an ORAL APPLIANCE is **medically necessary**.

Treatment duration will be at least one year, unless other interventions such as surgery occur, and could well be required for the remainder of your subscriber's life. ORAL APPLIANCE is used as an alternative to CPAP/BPAP or surgery. If you have questions, please contact the prescribing physician

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