Please include copies of any recent sleep studies.

FAX BACK TO:

Cleveland Clinic Dentistry

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Address: 9500 Euclid Ave/ A71 Cleveland, Ohio 44195

LETTER OF MEDICAL NECESSITY / REFERRAL FORM FOR ORAL APPLIANCE THERAPY

CODE – E0486 **QUANTITY-1**

Patient Name:	**DOB: ____/____/____ Age: ____**
Patient Phone #:	**Patient Address:**
Insurance Company: **Group No:** **Account/ID No:**	

Prescribing Physician:

NPI:

Primary Diagnosis: ◯ G47.33 (Obstructive Sleep Apnea) ◯ R06.83 (Snoring)

Secondary Diagnosis (Comorbidities):

Is this patient intolerant of PAP or not a candidate for PAP therapy?

❑ Intolerant of PAP ❑ Not a candidate for PAP ❑ Prefers not to use PAP

Duration of PAP Treatment:

Start Date _____ **End Date** _____ **Still Currently Using** _____ **Yes** _____ **No**

Description of Oral Appliance: *ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS*

I have attached the following documents needed to proceed with oral appliance treatment:

- ❑ Medical History and Medications
- ❑ Current Progress Notes
- ❑ Diagnostic Sleep Study
- ❑ Above documents are available in shared medical record

Physician Signature: _____ **Date:** _____

Statement of medical necessity: The above patient had a sleep-disordered breathing evaluation. 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 APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS" Treatment duration will be at least one year and could be required for the remainder of the patient's life. If you should have any questions, please contact the prescribing physician.