Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea

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

Patient Address:_____

Home:_____ **Cell:**_____ **Email:**_____

Patient Insurance:_____ **Insurance Phone:**_____

*Please fax a copy of patients medical insurance card with this prescription.

Prescription to be filled by:

Absolute Sleep of the Carolinas

166 Furman Rd. Ste A

Boone, NC 28607

(828) 832-8081

Fax: (828) 264-9939

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: _____

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 E04886 Mandibular Advancement Splint therapy with:

The appliance chosen by Dr. Steven Airey and the patient, as most suitable.

Signature of Referring Physician:_____

Date:_____ Office Name:_____ Office Tax ID:_____

Office NPI:_____ Doctors NPI #:_____

Office Address:_____ City:_____ State:____ Zip:_____

Fax #:_____ License #:_____