MD
MARKOWITZ DENTAL

CLARE A. MCGORRY, D.D.S.

Oral Appliance Referral, Order and Letter of Medical Necessity

Fax this order along with a copy of the **most recent sleep studies** and **most recent office visit clinical notes** to **Fax# (202) 331-7803**

Patient Information

Patient Name:_____ Date of Birth: _____ Sex: _____

Patient Address: _____

Patient Email: _____ Phone #: _____

Physician Information

Requesting Physician's Name: _____

Address:_____

Office E-mail: _____ Phone: _____ Fax: _____

Reason For Referral (Mark All That Apply)

Diagnosis:

- ☐ Obstructive Sleep Apnea (ICD10 G47.33)
- ☐ Sleep Apnea, Unspecified (ICD10 G47.30)
- ☐ Snoring (ICD10 R06.83)
- ☐ Other Sleep Apnea (ICD10 G47.39)
- ☐ Other diagnosis & ICD 10 Code: _____ _____

Therapies Attempted:

CPAP: ☐ Yes ☐ No ☐ Intolerant ☐ Not a good candidate

Surgery: ☐ Yes ☐ No ☐ Not a good candidate

Other: _____

Comments/ Special Concerns: _____

Mandibular Advancement Device Order

Physician Order: Mandibular Advancement Oral Device, Telescopic Herbst

Manufactured by Device Masters, FDA Reference # K955822

Medical Reason for Necessity

- ☐ Unable to tolerate CPAP
- ☐ High CPAP pressure may benefit from combination therapy
- ☐ Mild to Moderate OSA
- ☐ None, Primary Snoring

Statement of Medical Necessity

Due to the above noted history and physical information I am prescribing oral appliance therapy for this patient. This is medically necessary for the treatment of this diagnosis.

Physician's signature: _____ Date: _____

NPI#: _____