



**DENTAL SLEEP  
MEDICINE HAWAII**  
Solutions for Sleep Disorders

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**PATIENT INFORMATION**

Full Name: \_\_\_\_\_  
 Last First M.I.

Address: \_\_\_\_\_  
 Street Address Apartment/Unit #

\_\_\_\_\_ City State Zip Code

Home Phone: ( ) \_\_\_\_\_ DOB: \_\_\_\_\_ Email: \_\_\_\_\_

Requesting Physician's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Insured: Self  Child  Other  Medicare: YES  NO

Sleep Study Available: YES  NO

**REASON FOR REFERRAL (MARK ALL THAT APPLY)**

**Diagnosis:**  Obstructive Sleep Apnea (ICD G47.33)  Insomnia due to Sleep Apnea (ICD G47.30)

Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD G47.30)  Hypersomnia due to Sleep Apnea (ICD G47.30)

**Rx:**  Fabricate Custom Oral Appliance  Headaches (ICD G44.1)

TMJ Disorders (ICD M26.60)

**Therapies Attempted:**

CPAP: Intolerant  Not a good candidate  Surgery: YES  NO

Comments/ Special Concerns: \_\_\_\_\_

**Please include a copy of the patients sleep study, an RX stating the patient is CPAP intolerant, and the patients demographic sheet.**

**STATEMENT OF MEDICAL NECESSITY**

This above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed that an Oral Appliance is medically necessary. Oral Appliance Therapy (OAT) is used as an alternative to surgery at this time and or CPAP, as this patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_