

Tennessee Sleep Apnea & TMJ Solutions
Phone: (615) 850-8445 Fax: (615) 535-9992

PRESCRIPTION / LETTER OF MEDICAL NECESSITY

FOR ORAL APPLIANCE THERAPY

QUANTITY = 1 unit CPT Code: E0486 or K1027

Patient Name:	DOB:	Age:
Patient Phone #:	Patient Address:	
Insurance Company: Group No:	Prescription Date:	
Prescribing Provider:		
NPI:	Address:	
Tax ID:	Phone:	
Fax:		
Primary Diagnosis: <input type="radio"/> G47.33 (Obstructive Sleep Apnea) <input type="radio"/> R06.83 (Snoring)		
Secondary Diagnosis:		
As required by insurance, this patient is intolerant of CPAP or is not a candidate for CPAP therapy. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Duration of Treatment:		
Description of Oral Appliance: ORAL APPLIANCE (CPT CODE # E0486 or K1027) USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS		
Additional Physician Remarks:	PLEASE INCLUDE WITH PRESCRIPTION:	
	<input type="checkbox"/> Pre Test Note <input type="checkbox"/> Signed Sleep Study <input type="checkbox"/> Post Test Note <input type="checkbox"/> This Rx Form	
Provider Signature:	Date:	
<i>Statement of medical necessity: The above patient has had a sleep-disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea, and 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 provider.</i>		

RETURN TO:

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