Michigan Dental Sleep Center, Inc.

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Phone: (810) 659-1721 Fax: (810) 659-0897
MichiganDentalSleepCenter@gmail.com

Physician Order for Oral Appliance Therapy

Please fax **completed form, clinical notes** and **all related diagnostic testing,** (Baseline Sleep Study, etc.) to (810) 659-0897. We cannot schedule your patient without this information.

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Cell Phone: _____ Email: _____

Address: (Street, City, State, Zip) _____

INSURANCE INFORMATION

Primary Medical Ins: _____ ID#: _____ Group#: _____

Plan Name: _____ Card Holder's Name/DOB: _____

Diagnosis: Obstructive Sleep Apnea, Adult Pediatric G47.33

Oral Appliance Type: ☒ E0486 (Oral Appliance)

ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT

The above patient has had a confirmed diagnosis of obstructive sleep apnea and is opting for a custom-fabricated mandibular advancement device to treat their sleep apnea; the device is considered durable medical equipment and is medically necessary.

Signature: _____ Date: _____

PROVIDER INFORMATION

Referring Physician: _____

MD DO PA NP (Please circle)

NPI#: _____

Address: _____

Phone: _____ Fax: _____

Please fax this slip, baseline sleep study and other supporting documentation.

THANK YOU!