



Physician Referral Form

3960 El Camino Avenue, Suite 3

Sacramento, CA 95821

Phone: (916) 483-5566 Fax: (916) 483-0576

www.sacramentoDSM.com Upendra J. Patel, DDS, Inc. Email Documents: sleepwell@sacramentoDSM.com

Oral Appliance Therapy Rx & Medical Necessity Form for Medically Diagnosed Obstructive Sleep Apnea

Requesting Physician's Name: _____

Name of Organization/Company/Hospital: _____

Phone: _____ Fax: _____

Patient's Name: _____ DOB (Date of Birth): _____

Patient's Contact Number: _____

Notes: _____

Diagnosis:

- ☐ Obstructive Sleep Apnea – ICD G47.33
- ☐ Hypersomnia due to Sleep Apnea – ICD G47.10
- ☐ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified – ICD G47.30 (UARS)
- ☐ Sleep Apnea, other, Unspecified – ICD G47.30
- ☐ Temporomandibular Joint Dysfunction/ Orofacial Pain
- ☐ Other

Patient's Diagnostic Sleep Study Results (without CPAP or OA):

- ☐ Date of study: _____
- ☐ Respiratory Disturbance Index (RDI): _____
- ☐ Apnea Hypopnea Index (AHI): _____
- ☐ Oxygen Desaturation Index (ODI): _____
- ☐ Lowest O2 Saturation (SpO2): _____

Statement of Medical Necessity

I am referring the above patient to Dr. Upendra J. Patel, DDS, Inc because I believe it is Medically Necessary for him/her to be fitted for a custom fitted oral appliance, **E0486**

Physician's Signature: _____ Date: _____