Herman Ostrow
School of Dentistry
of USC

Orofacial Pain and Oral Medicine Center
Oral Appliance Referral Form For
Medically Diagnosed Obstructive Sleep Apnea
(Treatment Order and Medical Necessity)

Fax No: 213-740-3573

Patient Name:

Date of Birth:

Diagnosis:
___ Obstructive sleep apnea – ICD-10-CM G47.33
___ Hypersomnia due to Sleep Apnea -ICD-10-CM G47.30
___ Insomnia due to Sleep Apnea
___ Sleep Apnea, Other, Unspecified
___ Narcolepsy
___ Restless leg syndrome
___ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified -ICD 327.20 (UARS)

Treatment Orders:
___ Mandibular Advancement Device for treatment of OSA
___ Mandibular Advancement Device to be used in combination with CPAP

Medical Justification: (patient has tried CPAP and has not tolerated and/or complied with treatment for the following reasons)
___ Unable to tolerate mask/straps
___ Skin sensitivity
___ Unable to tolerate effective CPAP pressure
___ Claustrophobia
___ Other

Statement of Medical Necessity

Due to the history and diagnosis noted above, I am recommending oral appliance therapy for the treatment of this patient. I, the undersigned, certify the procedure prescribed above is medically necessary for the treatment of this sleep disorder.
Please send the Sleep study along with this referral form to the fax number above

Referring Physician:_____ .

Physician's Signature:_____ .

Date:_____ .