BERGEN TMJ
& DENTAL SLEEP CARE

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PATIENT INFORMATION

Name: ______________________ Phone: ______________________

REFERRING DOCTOR

Name: ______________________ Practice Name: ______________________

Phone: ______________ Fax: ______________ Email: ______________

REASON FOR REFERRAL

DIAGNOSIS:

☐ **Obstructive Sleep Apnea (ICD G47.30)**

☐ Insomnia due to Sleep Apnea (ICD G47.30)

☐ Hypersomnia due to Sleep Apnea (ICD G47.30)

RX: ☐ **Fabricate Custom Oral Appliance** Sleep Study Available: ☐ YES ☐ NO

THERAPIES ATTEMPTED:

CPAP: ☐ Intolerant ☐ Not a good candidate Surgery: ☐ YES ☐ NO

DOCTOR'S COMMENTS

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Please send a copy of patient's sleep study, clinical report, and an Rx stating CPAP intolerance.

STATEMENT OF MEDICAL NECESSITY

The above patient has undergone a sleep study confirming the diagnosis of a sleep-related breathing disorder. Based on this evaluation, it has been determined that an **Oral Appliance is medically necessary**. Oral Appliance Therapy (OAT) is being recommended as a non-surgical treatment alternative, as the patient has either been unable to tolerate CPAP therapy or does not believe they will be able to tolerate it.

Physician Signature: ______________________ Date: ______________________

License Number: ______________________ NPI Number: ______________________