P: 512-215-4350
F: 512-647-6367

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)*

Referring Physician _____ Tel: _____

Patient Name _____ DOB: _____

Patient Address _____

Patient Telephone _____

***Please include patient demographics, insurance, appointment notes, and sleep study (if the patient has one).**

Referral for:

☐ **Sleep Test**

-or-

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

☐ **Obstructive Sleep Apnea (G47.33)**

-or-

☐ **Simple Snoring**

Severity: _____

This patient is: (Optional)

☐ Intolerant of C-PAP therapy

☐ Not a candidate for C-PAP therapy

Prescription to be filled by: (Optional)

☐ **Sleep Better Austin - South**
5920 W. William Cannon Dr., Bldg #6, Ste. 200
Austin, TX 78749

☐ **Sleep Better Austin Central**
1600 West 38th St.
Austin, TX 78731

☐ **Sleep Better Austin - Temple**
3731 FM 93 ste 110
Temple, TX 76502

☐ **Sleep Better Austin - Cedar Park**
920 N. Vista Ridge Blvd., Ste. 700
Cedar Park. TX 78613

☐ **Sleep Better Austin - Georgetown**
4405 Williams Dr., Ste. 300
Georgetown TX 78628

☐ **Sleep Better Austin - Kyle**
4460 FM 1626, Suite 200
Kyle TX 78640

Duration (If OAT Referal): ☐ Lifetime

Notes: _____

Signature of Referring Physician: _____

DR. NPI # _____

Date: _____

As a physician, I deem this therapy to be medically necessary. I am prescribing a custom fabricated Oral Appliance (E0486,K1027) for the above named patient who has been diagnosed for sleep apnea (G47.33). I prescribe treatment utilizing an FDA approved Custom Fabricated Oral Appliance. Length of need is lifetime. I strongly urge you to cover the costs of this therapy. Failure to do so would place the patient's health in jeopardy.