KELLER DENTISTRY

MEIR N KELLER DDS MS
SLEEP - OROFACIAL PAIN - TMJ

PATIENT REFERRAL

Patient Name: _____ Phone: _____

Appointment Date & Time: _____

Please call 805-527-2266 to schedule your patient's appointment.

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.

Date of Sleep Study: _____ Sleep Laboratory: _____

Diagnosis:

- ☐ Obstructive Sleep Apnea (G47.33)
  - ☐ Mild ☐ Moderate ☐ Severe
- ☐ Insomnia due to Sleep Apnea
- ☐ Hypersomnia due to Sleep Apnea
- ☐ Sleep Apnea (other/unspecified)
- ☐ Primary Snoring
- ☐ Other: _____

Treatment Orders:

- ☐ Mandibular Advancement Device for treatment of OSA (HCPCS E0486-NU)
- ☐ Mandibular Advancement Device to be used in combination with CPAP
- ☐ Mandibular Advancement Device for treatment of Primary Snoring
- ☐ Matrix Titration Study

Medical Justification for the Recommendation of a Mandibular Advancement Device:

- ☐ Mild Sleep Apnea
- ☐ Moderate Sleep Apnea
- ☐ Unable to tolerate mask/strap
- ☐ Unable to tolerate effective CPAP pressure
- ☐ Skin sensitivity
- ☐ Claustrophobia
- ☐ Insufficient surgical outcome
- ☐ Other: _____

Statement of medical necessity: This patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis, and a Mandibular Advancement Device is medically necessary due to the justification(s) identified above.

Physician Name:_____ Phone: _____ Signature: _____

Medical License #: _____ NPI #: _____

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