west end dental
digital comprehensive dentistry &
dental sleep medicine

DATE: _____

Should the patient be diagnosed with obstructive sleep apnea or snoring and be prescribed oral appliance therapy, please return this form.

FAX BACK TO:

James A. Krippaehne, DMD, MAGD, D.ABDSM
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Fax: 503-222-0029 Phone: 503-224-7815

PRESCRIPTION FORM / WRITTEN ORDER FOR ORAL APPLIANCE THERAPY

CODE – E0486 QUANTITY-1

Patient Name:	**DOB**
Patient Phone #:	**Email Address:**
Insurance Company:	

Primary Diagnosis: ◯ G47.33 (Obstructive Sleep Apnea)

Secondary Diagnosis:

Is this patient intolerant of CPAP or not a candidate for CPAP therapy? ❑ Yes ❑ No

Duration of Treatment:

Description of Oral Appliance: *ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS . HCPCS/CPT E0486*

Additional Provider Remarks:

Provider Signature: _____ **Date:** _____

Printed Provider name:_____ **NPI** _____

Statement of medical necessity: The above patient has a sleep-disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an ORAL APPLIANCE is medically necessary. Currently, Medicare has a code (E0486) with the following descriptor, "ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS" Treatment duration will be at least one year and could be required for the remainder of the patient's life. If you should have any questions, please contact the prescribing physician.