**Referral**

Only highlighted areas are required.

**PATIENT INFORMATION**

Name (first/last): ______________________ M / F DOB ______________

Address: ________________________________________________

Phone: ______________________ Email: ______________________

## CERTIFICATE OF MEDICAL NECESSITY

- **Type:** New
- **Period of Need:** Lifetime
- **Medical Necessity:** To aid in the treatment of Sleep Apnea
- **Diagnosis:** OSA (327.23)
- **Equipment:** E0486 (Lab Processed OSA Appliance)

**RX: MANDIBULAR ADVANCEMENT ORAL APPLIANCE FOR OBSTRUCTIVE SLEEP APNEA (E0486)**

Signature: ______________________ Date: ______________

Print Doctor Name: ______________________ NPI: ______________

Phone: ______________________ Fax: ______________

Address: ________________________________________________

Patient has had a sleep study within the last 5 years ❏ Yes* ❏ No
*if yes, please attach if your office has a copy.

## The Sleep Rehab Team

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