DATE:

**FAX BACK TO:**


AADSM Qualified Dentist & ABPD Diplomate:
Talia Lafond, DMD, MDS

Address: 902 Antique Aly Yardley, PA 19067
Email: info@sleepdentalspa.com

**Fax: (267) 394-6774**

**Phone: (267) 394-6772**

## DENTAL SLEEP MEDICINE COLLABORATION REFERRAL FORM

| **Patient Name:**<br>**DOB: _____/_____/_____** | **Patient is being referred for:**<br>**(CHECK ALL THAT APPLY)** |
|---|---|
| **Patient Phone #:**<br><br>**Medical Insurance Company:** | ❑ Custom Oral Appliance Therapy (Code – E0486)<br>❑ NightLase Therapy (Code- 42299)<br>❑ TMJ Trigger Point Muscle Injections- (Code 20553) |
| **Group No:**<br><br>**Account/ID No:** | ❑ Lingual Frenectomy (Code- 41015)<br>❑ Lip Frenotomy (Code – 40806)<br>❑ Myofunctional (Therapy Code- 99205) |

**Prescribing Physician:**

**NPI:**

**Primary Diagnosis:** ❑ G47.33 (Obstructive Sleep Apnea) ❑ R06.83 (Snoring) ❑ M26.10 TMJ/Jaw popping
❑ M26.59 - Malocclusion or other dentofacial functional abnormalities ❑ Q38.0 Lip Tie ❑ Q38.1 - Ankyloglossia

**Secondary Diagnosis (Comorbidities):**

**Is this patient intolerant of PAP or not a candidate for PAP therapy?** ❑ N/A
❑ Intolerant of PAP ❑ Not a candidate for PAP ❑ Prefers not to use PAP
Duration of PAP Treatment (if applicable): Start Date _____ End Date _____ Still Currently Using? _____ Yes _____ No

**I have attached the following documents needed to proceed with oral appliance treatment:**
❑ Medical History and Medications ❑ **Diagnostic Sleep Study** ❑ Other_____
❑ Current Progress Notes ❑ PAP Trial Study

## LETTER OF MEDICAL NECESSITY IF ORAL APPLIANCE THERAPY IS PRESCRIBED

*Statement of medical necessity: The above patient had 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.*

**Physician Signature:** **Date: _____**

Comments: