DATE:

FAX BACK TO:

AADSM Qualified Dentist & ABPD Diplomate:
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NIGHTLASE® SNORING AND SLEEP APNEA TREATMENT

PHYSICIAN RECOMMENDATION + REFERRAL FORM

Patient Name: **DOB: _____/_____/_____**	**Patient is being referred for:** **(CHECK ALL THAT APPLY)**
Patient Phone #: **Medical Insurance Company:**	❑ **NightLase® Therapy** (Code- 42299) as a monotherapy or as a co-therapy ❑ **Custom Oral Appliance Therapy (Code – E0486)** **please complete our referral/letter of medical necessity form*
Group No: **Account/ID No:**	❑ This patient is NOT a suitable candidate for NightLase ® Therapy either because of previous airway surgery or severe comorbidities.

Physician:

NPI:

Primary Diagnosis: ❑ G47.33 (Obstructive Sleep Apnea) ❑ R06.83 (Snoring)
Severity: ❑ Mild ❑ Moderate ❑ Severe

Has this patient been prescribed any other snoring or sleep apnea treatment? ❑None
❑ PAP (CPAP, BiPAP or APAP) ❑ Oral Appliance Therapy ❑ Implantable device ❑ Surgery (T&A, UPPP, MMA) ❑ Other_____
If so, are they still currently using it? ❑ Yes ❑No

I have attached the following documents:
❑ Medical History and Medications ❑ Current Progress Notes ❑ **Diagnostic Sleep Study** ❑ Other_____

Physician NightLase® Recommendation

Our mutual patient has expressed interest in NightLase ® treatment for snoring and or sleep apnea. This patient could benefit from the NightLase ® procedure either as:

❑ Monotherapy ❑ Combination therapy (detail below please) ❑ Not a suitable candidate

Physician Signature: **Date: _____**

Comments:

SCAN FOR INFO AND EVIDENCE-BASED ARTICLES ABOUT THE NIGHTLASE® SNORING AND SLEEP APNEA PROCEDURE