6500 Busch Blvd Suite 104
Columbus, OH 43229

(o) 614-396-8286
(f) 855-858-4924

OHIO SLEEP TREATMENT LLC

Monday 8:30a - 5:30p
Tuesday 8:30a - 7:30p
Wednesday 8:30a - 4:00p
Thursday 7:30a - 5:30p
Friday 8:30a - 12:30p
***Lunch from 12p-1p***

## PRESCRIPTION FOR ORAL APPLIANCE FOR OBSTRUCTIVE SLEEP APNEA (E0486)(G47.33)

Referring Physician: _____ Physician Phone Number: _____

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Telephone Number: _____

**The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria and is being referred to Ohio Sleep Treatment, LLC for therapy to treat:**

- ☐ Obstructive Sleep Apnea (G47.33)
- ☐ Upper Airway Resistance Syndrome (G47.8)
- ☐ Primary Snoring (R06.86)

Severity: _____

Length of Need: ☐ Lifetime

Other: ☐ _____

**The Patient:**

- ☐ is PAP Intolerant
- ☐ is not a candidate for PAP therapy
- ☐ has mild to moderate sleep apnea and is using this as a first-line of therapy.

This appliance is ☐ the patient's first oral appliance
☐ a replacement appliance

Patient's Chief Complaint:_____

_____

**Signature of Referring Provider:** _____ **Date:** _____

**Oral Appliance Details - To be determined by AADSM Qualified Dentist**

Oral Appliance Lab: _____

Oral Appliance Model: _____

Oral Appliance Price: _____

Quantity: 1