BAYSAC
Dental Sleep Solutions

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PATIENT INFORMATION

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Home Phone: ( ) _____ DOB: _____ Email: _____

Requesting Physician's Name: _____ Email: _____

Insurance Provider: _____ HMO ___ PPO ___ POS ___ EPO ___ INDEM ___ MCR ___ MCD ___

Policy Number: _____ Group Number: _____ Employer: _____

Insured: Self ◯ Child ◯ Other ◯ Medicare: YES ◯ NO ◯

Sleep Study Available: YES ◯ NO ◯

REASON FOR REFERRAL (MARK ALL THAT APPLY)

Diagnosis:

☐ **Obstructive Sleep Apnea (ICD 327.23)**

☐ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD327.20)

☐ Insomnia due to Sleep Apnea (ICD 780.51)

☐ Hypersomnia due to Sleep Apnea (ICD 780.53)

☐ Other, Unspecified (ICD 780.57)

Rx:

☐ **Fabricate Custom Oral Appliance**

Without Appliance (CPAP or Oral Appliance):

Respiratory Disturbance Index (RDI) _____ Lowest Desaturation (SpO2) _____

Apnea Hypopnea Index (AHI) _____ Percentage of Time Below 90% _____

Therapies Attempted: CPAP: Intolerant ☐ Not a good candidate ☐ Surgery: YES ☐ NO ☐

Comments/ Special Concerns: _____

Please include a copy of the patients sleep study, an RX stating the patient is CPAP intolerant, and the patients demographic sheet.

STATEMENT OF MEDICAL NECESSITY

This above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed that an Oral Appliance is medically necessary. Oral Appliance Therapy (OAT) is used as an alternative to surgery at this time and or CPAP, as this patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

Physician's Signature: _____ Date: _____