Paul Jacobs DDS, Diplomate, ABDSM
429 South Lincoln Rd.
Escanaba, MI 49829

PH: 906-786-7878 FAX: 906-786-0548
dr.paul.jacobs@gmail.com

Upper Peninsula Sleep DENTISTRY

American Academy of Dental Sleep Medicine
Dental Sleep Medicine Accredited Facility

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea And Verification of Medical Necessity Form

In order to facilitate prompt insurance reimbursement for our mutual patient, please sign and fax or email **this form** with a copy of the most recent **diagnostic sleep test results** (if available) to the office address listed at the bottom of this document. Once the sleep apnea appliance is in place, a follow-up study will be required to validate the efficacy of treatment. We will contact your office to have you arrange this for the patient.

TREATING PHYSICIAN INFORMATION		
Physician Name:	Physician Phone #:	
Office Address:	City:	Zip:

PATIENT INFORMATION		
Patient Name:	DOB:	
Cell Phone #:	Home Phone #:	
Address:	City:	Zip:

PRESCRIPTION INFORMATION

Prescription to be filled by: Paul Jacobs DDS, D,ABDSM — Upper Peninsula Sleep Dentistry

The patient referred with this form has been evaluated by the above physician and has been diagnosed, using acceptable medical criteria, to have: **(CHECK ALL THAT APPLY)**

- ☐ ICD 10 G47.33—*Obstructive Sleep Apnea*
- ☐ ICD 10 G47.30—*Hypersomnolence w/ Sleep Apnea* (Excessive Daytime Sleepiness)
- ☐ ICD 10 G47.30—*Upper Airway Resistance Syndrome*
- ☐ ICD 10 G47.30—*Insomnia w/ Sleep Apnea*
- ☐ ICD 10 G47.61—*Sleep-Related Limb Movement*

Apnea Hypopnea Index (AHI): _____ Respiratory Disturbance Index (RDI): _____

Minimum Oxygen Saturation (SpO2 Nadir): _____

Date of Last Diagnostic Sleep Test: _____ Date of Titration Sleep Test: _____

***REQUIRED – CHECK ONE BELOW FOR INSURANCE COVERAGE:**

*☐ The patient **prefers OAT** over CPAP or surgical alternatives for Mild or Moderate OSA.

*☐ The patient is **CPAP intolerant or non-compliant**.

*☐ The patient requires **combination therapy** of OAT in conjunction with CPAP.

*☐ The patient is not a candidate for CPAP Therapy.

Explanation (if necessary):

MEDICAL NECESSITY VERIFICATION AND PRESCRIPTION AUTHORIZATION

As the patient's treating physician, I deem this therapy to be MEDICALLY NECESSARY.

PHYSICIAN'S NPI#: _____ PHYSICIAN'S LICENSE #: _____

PHYSICIAN'S SIGNATURE: _____ DATE:_____