

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)*



p. 906.242.2443

f. 833.249.5211

Referring Physician: _____ Tel: _____

Patient Name: _____

Patient Address: _____

Patient Telephone: _____

**Please fax copy of patient's medical insurance card with this prescription.*

Prescription to be filled by Levätä Sleep.

**The patient referred with this form has been evaluated by the above
physician and has been diagnosed using acceptable medical criteria to have:**

Obstructive Sleep Apnea Severity: _____

-or- _____

Simple Snoring

This patient is:

Intolerant of C-PAP therapy

Is not a candidate for C-PAP therapy

Explanation (if necessary): _____

**The patient is being referred for E0486 Mandibular Advancement Device
therapy with:**

The appliance chosen by Levätä Sleep and the patient, as most suitable

Signature of Referring Physician: _____

Date: _____

As a physician, I deem this therapy to be medically necessary.

Please fill out this prescription form in its entirety.

**Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.*