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): ____________________

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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.*