North Florida Sleep Resources

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Date: ____________________

Patient Name: ____________________ DOB: ____________________

Patient Phone: ____

I am prescribing a Mandibular Advancement Device (E0486 or K1027) for the above-named patient who has been diagnosed with Obstructive Sleep Apnea (G47.33).

Severity: ☐ Mild ☐ Moderate ☐ Severe

Patient declined CPAP or is CPAP intolerant: ☐ Yes ☐ No

Patient has one of the following Comorbidities: ☐ Hypertension

☐ Excessive Daytime Sleepiness ☐ Insomnia ☐ Mood Disorder

☐ Impaired Cognition ☐ Ischemic Heart Disease ☐ History of stroke

I concur that the recommended therapy is medically necessary, and I now prescribe treatment, utilizing an FDA approved Mandibular Advancement Device. Length of need is lifetime. I strongly urge you to cover the costs of this therapy. Failure to do so would place the patient's health in jeopardy.

Physicians Name: ____

Physicians NPI: ____

Physicians Signature: ____

***Please include patient demographics, insurance, appointment notes, and sleep study (if the patient has one).**