

Referral Form

Phone: (516) 506-0000

Fax: (516) 336-3664

Email: Info@ChaseDentalSleepCare.com

Today's Date	Date of Birth
Last Name	First Name
Address	
Insurance Carrier	Member ID #
Home Phone #	Cell Phone #
Email	Doctor: _____
Physician's Signature	NPI# : _____

Diagnosis:	Treatment Options:
<input type="checkbox"/> Obstructive Sleep Apnea (Dx: G47.33) <input type="checkbox"/> Upper Airway Resistance <input type="checkbox"/> Primary Snoring <input type="checkbox"/> Suspected TMJ Disorder <input type="checkbox"/> Other _____	<input type="checkbox"/> Mandibular Advancement Device (CPT: E0486) <input type="checkbox"/> Oral Appliance Therapy for Treatment of TMJ <input type="checkbox"/> Botox <input type="checkbox"/> Other _____

Medical Justification:	Other notes:
<input type="checkbox"/> MAD (E0486) recommended as initial therapy <input type="checkbox"/> Patient is non-tolerant / non-compliant with PAP Therapy <input type="checkbox"/> Medically necessary for MAD in addition to PAP Therapy <input type="checkbox"/> 4 years of using the oral appliance (E0486) is medically necessary for this patient's medical condition, with re-evaluation in 36 months	_____ _____ _____

Documents Needed for Authorization

<input type="checkbox"/> Diagnostic Sleep Study	<input type="checkbox"/> Encounter Notes Prior To Study	<input type="checkbox"/> Prescription for Oral Appliance Therapy (THIS FORM CAN BE USE AS YOUR PRESCRIPTION)
	<input type="checkbox"/> Encounter Notes After Study	

Please Fax To: (516) 336-3664