SLEEP WELL
Southeast Texas

Oral Appliance Referral Form for the Treatment of Obstructive Sleep Apnea

Patient's Information

Full Name: ______________________________
Last First M.I.

Address: ______________________________
Street Apartment/Unit #

____
City State ZIP

Phone: ______________ **DOB:** ________ **Email:** ______________

Physician's Name: ______________________________

Physician's Email: ______________________________

Medical Insurance Information:

Insurance Provider: HMO PPO POS EPO Indem MCR MCD

Policy #: ________ **Group Number:** ________ **Employer:** ________

Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Sleep Study Available: Yes ☐ No ☐ **Medicare:** Yes ☐ No ☐

Reason For Referral (Mark All That Apply)

Diagnosis:

Obstructive Sleep Apnea (ICD 327.23) ☐ Insomnia Due to Sleep Apnea (ICD 780.51) ☐
Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD 327.20) ☐
Hypersomnia Due to Sleep Apnea ☐ Other, Unspecified (ICD 780.57) ☐

Statement of Medical Necessity

I am requesting Sleep Well Southeast Texas evaluate my patient and treat, if medically necessary.

Doctor's Signature: ______________________________ **Date:** ________

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