SNOREEXPERTS
Barbara Burggraaff, M.D., Medical Director - Board Certified Sleep Physician
Jonathan Greenburg, DDS | Jay Khorsandi, DDS | Stephanie Colletta, DDS
www.SnoreExperts.com ▪ PH. **(888) 317-6673** ▪ FAX. **(818) 796-3322**
Exclusively Treating Snoring, Sleep Apnea & CPAP Intolerance

PHYSICIAN ORDER FORM AND STATEMENT OF MEDICAL NECESSITY

PATIENT INFORMATION

Patient Name: _____ DOB: _____ /_____ /_____ Gender: ☐ M ☐ F

Address: _____ City: _____ State: ____Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____

****PPO Insurance:** attach copy of front and back of insurance card **- Medicare:** attach copy of card plus front and back of supplement

PRESCRIBED SERVICE(S)

(Please Check all that apply)

☐ E0486 Custom Oral Appliance to treat OSA (Obstructive Sleep Apnea) Due to CPAP/APAP Intolerance
☐ Home Sleep Study
☐ APAP/CPAP Therapy

Notes: _____

DX CODES

☐ICD 10 code **# G 47.33**
Obstructive Sleep Apnea

HISTORY & SYMPTOMS

(Please Check all that apply)

□ HISTORY OF WITNESSED APNEAS
□ LOUD, HEAVY SNORING OFTEN INTERRUPTED BY SILENCE & GASPS
□ HISTORY OF EXCESSIVE DAYTIME SLEEPINESS (EDS)
□ OBESITY
□ HEART DISEASE
□ STROKE
□ IMPAIRED COGNITION
□ MOOD DISORDER
□ HYPERTENSION
□ INSOMNIA
□ OTHER *(PLEASE SPECIFY)*: _____

REFERRING PHYSICIAN

I certify that the above service(s) prescribed by me is/are medically indicated and in my opinion is/are reasonable and necessary with reference to all professionally recognized medical standards and treatment of this patient's condition.

Name: _____ TEL: (___) _____ FAX: (___) _____

Physician Signature: _____ DATE: _____

For questions please contact **Snore Experts @ (818) 205-1122**

PLEASE FAX THIS **SIGNED** FORM TO **(818) 796-3322**

***ATTACH SLEEP STUDY IF COMPLETED & INSURANCE INFORMATION**