



Sleepwatchers, PLLC

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ORAL APPLIANCE THERAPY (OAT) ORDER

Patient: _____ DOB: _____ Mobile #: _____

1.	OAT OPTIONS
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☐ Prefabricated Dental Device

☐ Custom Dental Device

☐ Patient Preference

2.	QUALIFYING QUESTIONS for MEDICAL NECESSITY / APPROPRIATENESS
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Has the patient been diagnosed with Obstructive Sleep Apnea in the last year? (Please attach SS Report)	Y	N
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Has the patient attempted CPAP therapy and been unable to tolerate it?	Y	N
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Will the patient use this option in conjunction with CPAP? (Please attach a CPAP Order Form)	Y	N
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Does the patient have any significant dental work to be done soon*?	Y	N
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Does the patient have any missing teeth or a dental bridge*?	Y	N
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(*Some dental conditions will postpone fitting or disqualify the patient from Oral Appliance Therapy)

3.	SLEEP TESTING for OAT TITRATION
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☐ Home Sleep Test (To Be Performed After Final HOME Titration / Adjustment of Dental Device)

☐ In-Lab Polysomnogram w/ Oral Appliance Titration (To Be Performed ~ 4 to 6 Weeks After Initial OAT Set Up)

4.	DIAGNOSIS: ICD & Description
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☐ OBSTRUCTIVE SLEEP APNEA (G47.33)

☐ COMPLEX SLEEP APNEA (G47.31, G47.33)

☐ OTHER:

☐ OTHER:

☐ OTHER:

☐ OTHER:

LENGTH OF EQUIPMENT NEED: _____ MONTHS (99 = LIFETIME)

5.	ORDERING PROVIDER
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NAME:

PHONE #:

NPI#:

FAX #:

PROVIDER SIGNATURE _____ DATE _____

PLEASE ATTACH ANY MEDICAL RECORDS THAT SUPPORT MEDICAL NECESSITY

FAX TO: (888) 608-0343