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**DORFNER DENTAL**  
SLEEP STUDIO

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

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 has declined CPAP or is CPAP intolerant:**

**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).