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Chesapeake Sleep Center

Sleep well. Live well.

Connect with us:
O: (410) 729-6794
F: (410) 760-4561
www.ChesapeakeSleepCenter.com

Oral Appliance Referral Form

Patient Name: _____
Last Name, First Name, Middle Initial

Date of Birth: _____ Patient Phone: _____

Insurance Information:

Insurance Company: _____

Subscriber Name: _____
Last Name, First Name, Middle Initial

Subscriber Date of Birth: _____ Relationship to Subscriber: _____

ID Number: _____

Group Number: _____

Diagnosis:

_____ Obstructive sleep apnea
_____ Hyperinsomnia due to sleep apnea
_____ Insomnia due to sleep apnea
_____ Sleep apnea/sleep related breathing disorder, unspecified
_____ Sleep apnea, other, unspecified
_____ Other:

Special Notes: ☐ Sleep study attached

Statement of Medical Necessity

The above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an oral appliance is medically necessary.

Practice Name: _____ Physician's Name: _____

Practice Address: _____ Phone Number: _____

Physician's Signature: _____ Date: _____

Please fax form to (410) 760-4561 or scan and email to prmdds@aol.com.