MARIANNA L. KOVITCH, D.M.D.
DIPLOMATE, AMERICAN BOARD OF DENTAL SLEEP MEDICINE
DINA J. GIESLER, D.D.S., M.A.G.D.

Date:____________________Referring Doctor:______________________

Patient Name:__________________________ D.O.B.________________

Referral Request

❑ Consult for Sleep Apnea Appliance

Treatment with oral appliance

Due to the following: (check all that apply)

❑ CPAP intolerant
❑ Mild/Moderate OSA
❑ Insufficient Surgical Outcome
❑ Primary snoring
❑ Adjunct to CPAP therapy

Records Request

❑ Sleep Study (please fax to number below)

Prescription for Oral Appliance Therapy for Medically Diagnosed Obstructive Sleep Apnea

Physician Name: ____

Diagnosis: Obstructive Sleep Apnea (OSA)

Please fabricate a custom oral appliance (HCPCS Code E0486) to treat Obstructive Sleep Apnea

Physician Signature: ____

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