



## Prescription for Oral Appliance Therapy

To: ☐ Dr. Todd Coy, DMD  
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☐ Dr. Betty Haberkamp, DDS  
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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**I am writing to inform you that it is medically necessary for the above patient to be fitted for an oral appliance. (Mandibular Advancement Device)**

*This Patient:*

☐ Was diagnosed with Obstructive Sleep Apnea (ICD-10 G47.33)

☐ Mild

☐ Moderate

☐ Severe

☐ Was not diagnosed with sleep apnea, but due to other disordered breathing, I have suggested an oral appliance for mandibular repositioning.

*This Patient:*

☐ Is not tolerant of CPAP therapy

☐ Is not a candidate for CPAP therapy

*Explanation (if necessary)* \_\_\_\_\_

☐ Requires combination therapy, adding a mandibular advancement device with their CPAP machine

☐ Was advised CPAP was the gold standard, but still requests a mandibular advancement device

Physician Signature: \_\_\_\_\_

Sig: \_\_\_\_\_

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

Phone: \_\_\_\_\_