SLEEPCYCLECENTER
A GOOD NIGHT'S REST BEGINS HERE

ATX - 10900 Research Blvd. STE 140-C, Austin TX 78759
LWY - 317 Ranch Rd 620 S, STE. 101, Lakeway, TX 78734
Phone: (512) 645-0148 **Website:** www.sleepcyclecenters.com

PLEASE COMPLETE & FAX TO: (512) 645 – 0646
OR EMAIL FORM: REFERRALS@SLEEPCYCLECENTER.COM

Patient Name: ______________________
DOB: ______________________
Phone: ______________________
Email: ______________________
Address: ______________________
Insurance Provider: ______________________
Insurance Policy Number: ______________________
Insurance Phone Number: ______________________
Insurance Group ID: ______________________

Referring Physician Name: ______________________
License: ______________________
NPI: ______________________
Phone: ______________________
Email: ______________________
Office Name: ______________________
Address: ______________________
Office Tax ID: ______________________
Office NPI: ______________________

PRESCRIPTION FOR AT-HOME SLEEP TEST

Sleep History & Presenting Symptoms:

- ☐ Snoring
- ☐ Witnessed Apnea
- ☐ Morning Headaches
- ☐ Nocturia
- ☐ Daytime Sleepiness
- ☐ Fatigue
- ☐ Congestive Heart Failure
- ☐ Nocturnal Awakenings
- ☐ Impaired Cognition
- ☐ Diabetes
- ☐ Insomnia
- ☐ Non-Restorative Sleep
- ☐ Bruxism
- ☐ Restless Leg / Periodic Limb Movements
- ☐ Central Sleep Apnea
- ☐ Stroke
- ☐ Hypertension
- ☐ Obesity (BMI: ______)
- ☐ Other Symptoms: ________________

Suspectected Diagnosis:

	Diagnosis	Code
☐	R/O Sleep Apnea	G47.33
☐	Treat OSA	G47.33
☐	Treat CSA	G47.31
☐	Treats Complex SA	G47.31
☐	Re-Titration for OSA	G47.33
☐	R/O	G47.61
☐	R/O Narcolepsy	G47.419
☐	Restless Leg Syndrome	G25.81
☐	Snoring	R06.83
☐	Other: _____________	G47.33

☐ **Testing Consultation & Treatment Management**

(Once the study is completed, Sleep Cycle Center will review the Results with the patient at a consultation appointment after the study. Initiation of treatment and on-going management by Board-Certified Sleep Physician & Sleep Cycle Center.)

______________________________ ____________
(PROVIDER SIGNATURE) ***(DATE)***

PRESCRIPTION & LOMN FOR ORAL APPLIANCE THERAPY FOR OBSTRUCTIVE SLEEP APNEA

This Patient Is:

- ☐ intolerant of CPAP therapy
- ☐ in *not* a candidate for CPAP therapy
- ☐ G47.33 Obstructive Sleep Apnea
- ☐ R06.83 Snoring
- ☐ Other: ______________

The Patient Is Being Sent For E0486 Mandibular Advancement Splint Therapy With:

☐ The appliance chosen by the Patient and Sleep Cycle Center, as most suitable

Letter of Medical Necessity for the Treatment of Obstructive Sleep Apnea (OSA)

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. Currently, Medicare has a code (E0486) with the following descriptor "Oral Device/Appliance used to reduce upper airway collapsibility, adjustable or non adjustable, custom fabricated includes fitting and adjustment." Treatment duration will last a minimum of one year barring the Occurrence of other intervening measures, such as surgery, and could be required for the remainder of the subscriber's life Oral appliance therapy is used as an alternative to surgery and/or CPAP. Please contact the prescribing physician with any questions. I am recommending oral appliance therapy for the treatment of this patient. I, the undersigned, certify the procedure prescribed above is medically necessary for the treatment of this sleep disorder.

______________________________ ____________
(PROVIDER SIGNATURE) ***(DATE)***

PRESCRIPTION FOR WEIGHT LOSS & NURTRITIONAL COUNSELING

This Patient Is Diagnosed With:

- ☐ Fatigue
- ☐ Diabetes
- ☐ Stroke
- ☐ Hypertension
- ☐ Obesity (BMI: ____)
- ☐ Other Symptoms: ___________

☐ **This Patient Could Benefit From Weight-Loss & Nutritional Couseling**

______________________________ ____________
(PROVIDER SIGNATURE) ***(DATE)***