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[www.SnoreExperts.com](http://www.SnoreExperts.com) ▪ PH. (818) 578-3500 ▪ FAX. (818) 796-3322

**Exclusively Treating Snoring, Sleep Apnea & CPAP Intolerance**

4418 Vineland Ave #112 Toluca Lake, CA 91602

**PHYSICIAN ORDER FORM AND STATEMENT OF MEDICAL NECESSITY**

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

**\*\*PPO Insurance:** attach copy of front and back of insurance card - **Medicare:** attach copy of card plus front and back of supplement

**ATTACH SLEEP STUDY IF COMPLETED**

**PRESCRIBED SERVICE(S)**

*(Please check all that apply)*

E0486 Custom Oral Appliance for (Obstructive Sleep Apnea) due to CPAP/APAP Intolerance

Home Sleep Study

APAP/CPAP Therapy

Notes: \_\_\_\_\_

**HISTORY & SYMPTOMS**

*(Please check all that apply)*

**DX CODES**

CD 10-code # **G 47.33**

Obstructive Sleep Apnea

- HISTORY OF WITNESSED APNEAS
- LOUD, HEAVY SNORING OFTEN INTERRUPTED BY SILENCE & GASPS
- HISTORY OF EXCESSIVE DAYTIME SLEEPINESS (EDS)
- OBESITY
- HEART DISEASE
- STROKE
- IMPAIRED COGNITION
- MOOD DISORDER
- HYPERTENSION
- INSOMNIA
- OTHER (PLEASE SPECIFY) \_\_\_\_\_

**REFERRING PHYSICIAN**

I certify that the above service(s) prescribed by me is/are medically indicated and in my opinion is/are reasonable and necessary with reference to all professionally recognized medical standards and treatment of this patient's condition.

Name: \_\_\_\_\_ TEL: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

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

Contact us with questions @ **(818) 578-3500** or **Info@SnoreExperts.com**

**PLEASE FAX/EMAIL THIS SIGNED FORM TO (818)796-3322**