SNOREEXPERTS
Jonathan Greenburg, D.D.S., F.A.G.D. ▪ Jay B. Reznick D.M.D., M.D.
www.SnoreExperts.com ▪ PH. (818) 578-3500 ▪ FAX. (818) 796-3322
Exclusively Treating Snoring, Sleep Apnea & CPAP Intolerance
Tarzana ▪ Newport Beach ▪ Pasadena

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:

DX CODES

☐ICD 10-code **# G 47.33**

Obstructive Sleep Apnea

HISTORY & SYMPTOMS

(Please check all that apply)

□ 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**