ORAL APPLIANCE THERAPY
ORDER

Date: _____

From (ordering provider):

Physician Name: _____
NPI: _____
Phone: _____
Address: _____

To (servicing DME provider):

Spokane Sleep Apnea Dentistry
Dr. Liana Groza DDS DABDSM
12213 E. Broadway Ave. Suite 4
Spokane Valley, WA 99206
Tel. (509) 290-6044 Fax (509) 443-3928

Patient Name: _____

Patient Date of Birth: _____

Patient Phone: _____

Diagnosis: Obstructive Sleep Apnea – ICD-10 G47.33
Rx: Mandibular Advancement Device E0486
Length of Need: 99 months

Due to history and diagnosis noted above, I am recommending Oral Appliance Therapy E0486 for the treatment of this patient.

Referring Physician Signature: _____

Please fax patient demographics, diagnostic sleep study and relevant clinical notes to (509) 443-3928