FORT WORTH
SNORING & SLEEP CENTER

451 University Drive Ste 102
Fort Worth, TX 76107
P: 817-527-8500
F: 817-527-8512
www.fortworthsnoringandsleepcenter.com
office@fortworthsnoringandsleepcenter.com

Sleep Referral Form

Date _____

Patient Name Mr. / Mrs. _____

Patient DOB _____

Patient Phone Number _____

PLEASE INCLUDE COPY OF PATIENT'S MEDICAL INSURANCE CARD FRONT AND BACK

Referring for: (circle one)

TMD/TMJ Therapy

Sleep Apnea Evaluation/Testing

Snoring Treatment

OSA Treatment/CPAP/CPAP Intolerant-Appliance

Last Sleep Study: (check one) __ never tested __ tested: date_____

For Referral for Oral Appliance Treatment: Unlike CPAP approval, insurance requires the following information to approve a preauthorization for appliance therapy. Please send us copies of these items.

- *Office notes from the physician that recommended the most recent sleep study stating the need for the study to be taken. (dated before sleep test) – we can also order the initial test if you prefer*
- *Copy of a sleep study signed by a Board Certified Sleep Physician scored at 4% desaturation. This test needs to be less than 2 years old.*
- *Signed Prescription for the Mandibular Advancement Device (include DX G47.33 and CPT E0486)*
- *Separate office notes from the prescribing physician mentioning their conversation with the patient post-sleep study and recommendation for oral appliance therapy. Needs to include the test scores. If they have severe apnea, or have tried PAP therapy already, this note needs to contain information mentioning these points as well and why they aren't using or trying PAP such as claustrophobia etc. (dated after sleep test)*

Delay in obtaining these items, will delay insurance approval and delay the patient from receiving treatment. We appreciate your assistance. After items are returned to us, we will let you know if we need any additional information or something changed by the physician.

Notes:

Referring Physician_____ Facility_____

Phone Number_____ Contact_____