



Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)

Referring Physician: _____ Tel: _____

Patient Name: _____

Prescription to be filled by:

30A Sleep Solutions

Julie Vilardo, DDS

2930 W Co Hwy 30A, Suite 102 | Santa Rosa Beach, FL 32459

P: 850.931.8736 | F: 877.650.7378

**Please fax a copy of the patient's medical insurance card with this prescription*

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable criteria to have:

☐ Obstructive Sleep Apnea Severity: _____

Or

☐ Simple Snoring

This patient is:

☐ Intolerant of C-PAP therapy

☐ Is not a candidate for C-PAP therapy

Explanation (if necessary): _____

The patient is being referred for E0486 / K1027 Mandibular Advancement Device therapy with:

☐ The appliance chosen by 30A Sleep Solutions and the patient, as most suitable

☐ Length of Treatment: Lifetime

As a physician, I deem this therapy to be medically necessary.

Signature of Referring Physician: _____

Date: _____ Physician NPI: _____

Please fill out this prescription in its entirety.

**Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician*
