Prescription For Oral Appliance Therapy for Obstructive Sleep Apnea*

Referring Physician: _____ NPI: _____

Office Address: _____

Office Telephone: _____ Fax: _____

Patient Name: _____ DOB: _____/_____/_____

Patient Address: _____

Patient Telephone: _____

DME Prescription to be filled by:
Dr. Mitch Conditt
451 University Dr, Ste 102 | Fort Worth, TX 76107
P: 817-527-8500 | F: 817-527-8512

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

❑ Obstructive Sleep Apnea G47.33 ❑ Mild ❑ Moderate ❑ Severe
❑ Simple snoring

The patient is:
❑ Intolerant of PAP therapy
❑ Patient refused PAP therapy
❑ Is not a candidate for PAP therapy or not severe enough to need PAP therapy

The patient is being sent for Oral Appliance (OA) therapy with: **CHECK ALL THAT APPLY**

❑ The PDAC approved appliance chosen by Dr. Conditt and the patient as most suitable
❑ An Initial oral appliance
❑ A replacement oral appliance. Previous appliance needs replacement because _____.

Signature of referring physician:

_____ Date: _____

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