WEST VIRGINIA
Sleep Solutions
A Dental Solution for Restful Sleep

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

Referring Physician: _____ Tel: _____
Patient Name: _____
Patient Address: _____
Patient Telephone: _____
Prescription to be filled by:

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

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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 Severity: _____
-or-
❑ Simple Snoring

This patient is:
❑ Intolerant of C-PAP therapy ❑ Is not a candidate for C-PAP Therapy

Explanation (if necessary)

_____

_____

Notes:

_____

_____

_____

Signature of Referring Physicians: _____

Date: ____/____/_____ *As a physician, I deem this therapy to be medically necessary.*
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.*