



MINNESOTA
**HEAD & NECK
PAIN CLINIC**

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Today's Date: _____

Referral Prescription for Oral Appliance Therapy

HCPCS 2014 Code EO486

Patient Name: _____ DOB: _____ Phone: _____

M.D. Name: _____ M.D. Signature: _____

Date of sleep study ____/____/____ Return to M.D. Date ____/____/____

Diagnosis:

Obstructive sleep apnea (ICD-10 G47.33)

(Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment.)

Other _____ ICD-10 _____

Consult and treat with oral appliance therapy

AHI _____ RDI _____

Consult

Thank you for your referral

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