MINNESOTA
HEAD & NECK
PAIN CLINIC

www.mhnpc.com

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Minneapolis / St. Paul
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❑ Please send more referral pads

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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