P: 316-542-6088

F: (316) 773-4592

Houlik DENTISTRY

NPI: 1700231271

Practice NPI: 141743533

Oral Appliance Prescription/LOMN

Referring Physician: _____ Tel: _____

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Telephone: _____

***Please include patient demographics, insurance, appointment notes, and sleep study (if the patient has one).**

Referral for:

☐ **Sleep Test**
-or-

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)**
-or-

☐ **Simple Snoring**

This patient is:

☐ Intolerant of C-PAP therapy

☐ Not a candidate for C-PAP therapy

Our Location (patient can choose when scheduling):

☐ 2759 N Tyler Rd, Wichita, KS 67205

Duration (If OAT Referral):

Notes: _____

Signature of Referring Physician: _____

DR. NPI #: _____

Date: _____

***Note: Please FAX or physically bring in form to office. Do not email using non-encrypted email platform.**

As a physician, I deem this therapy to be medically necessary. I am prescribing a custom fabricated Oral Appliance (E0486,K1027) for the above named patient who has been diagnosed for sleep apnea (G47.33). I prescribe treatment utilizing an FDA approved Custom Fabricated Oral Appliance. Length of need is lifetime. I strongly urge you to cover the costs of this therapy. Failure to do so would place the patient's health in jeopardy.