DENTAL SLEEP SOLUTIONS of Greenville & McKinney

SLEEP APNEA & SNORING TREATMENT
DR. KYLE M. SMITH
DR. KATHARINE EVANS

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Suite 1502
McKinney, TX 75070
(Phone) 214-592-8042

Greenville Location
4818 Wellington Street
Suite 3
Greenville, TX 75402
(Phone) 903-455-0516

Please Fax or Email Prescription to:
Fax: 903-455-5888
Email: smithdentistry@protonmail.com

www.SleepApneaDFW.net

Prescription & Letter of Medical Necessity for Oral Appliance Therapy

Patient :_____ **Date of Birth:_____**

Patient Phone Number: _____

Patient Signs & Symptoms:

_____ Chronic Snoring
_____ Poor Sleep Quality
_____ Witnessed Apneas
_____ Gasping or Choking at night
_____ Daytime Fatigue
_____ Nighttime GERD
_____ Headaches
_____ Sleep Bruxism
_____ Anxiety or Depression
_____ Other _____

_____ The patient is unable or unwilling to tolerate PAP therapy.

Diagnosis

___ The patient has been diagnosed with Obstructive Sleep Apnea, Adult/Pediatric G47.33 (mild moderate severe)
___ Other: _____

Additional Information, if needed:

_____
_____

Practice and/or Provider Name**:** _____
Address: _____
City: _____ Zip: _____
Office Phone: _____ Fax: _____

This Prescription is to treat this patient with Oral Appliance Therapy, E0486 or K1027, if applicable.

LETTER OF MEDICAL NECESSITY FOR OBSTRUCTIVE SLEEP APNEA ORAL APPLIANCE THERAPY

The above referenced patient has an absolute Medical Necessity for Obstructive Sleep Apnea. I certify that the above-prescribed oral appliance is medically indicated and in my opinion is reasonable and medically necessary with reference to the standards of medical practice for this patient's condition.

Referring Provider Name: _____

Provider Signature: _____ Date: _____

Provider NPI # _____

(Form last Updated 8/2025)