Cleveland Clinic

Prescription for Oral Appliance Therapy

To: ☐ Dr. Todd Coy, DMD
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Cleveland, Ohio 44195
216-444-4802

☐ Dr. Betty Haberkamp, DDS
9500 Euclid Avenue, A71
Cleveland, Ohio 44195
216-444-6397

Patient Name: _____ DOB: ____/____/____

I am writing to inform you that it is medically necessary for the above patient to be fitted for an oral appliance. (Mandibular Advancement Device)

This Patient:

☐ Was diagnosed with Obstructive Sleep Apnea (ICD-10 G47.33)

☐ Mild ☐ Moderate ☐ Severe

☐ Was not diagnosed with sleep apnea, but due to other disordered breathing, I have suggested an oral appliance for mandibular repositioning.

This Patient:

☐ Is not tolerant of CPAP therapy

☐ Is not a candidate for CPAP therapy
Explanation (if necessary) _____

☐ Requires combination therapy, adding a mandibular advancement device with their CPAP machine

☐ Was advised CPAP was the gold standard, but still requests a mandibular advancement device

Physician Signature:

Sig: _____ Date: _____

Phone: _____