Superior Sleep and Wellness

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea

Name of Physician (Print): ____ **Tel:** ____________________

Patient Name: ____ **Patient DOB:** ____________________

Patient Address: ____

Patient Phone: ____________________ **Patient Email:** ________________________________

Patient Insurance: __________________________ **Insurance Phone:** __________________________

** Please fax a copy of the patient's medical insurance card with this prescription.*

Prescription to be filled by:
Dr. Frank Holecek
Superior Sleep and Wellness LLC
2510 South Rochester Road Suite B
Rochester Hills, MI 48307
P: (248) 844-1415
F: (248) 844-1864

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

☐ G47.33 Obstructive Sleep Apnea ☐ Simple Snoring Severity: ________________________

This patient is:

☐ Intolerant of C-PAP Therapy ☐ Use for Travel ☐ Is not a candidate for C-PAP Therapy

Explanation (if necessary): ____

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The patient is being sent for E0486 Mandibular Advancement Splint Therapy with:

☐ The appliance chosen by Dr. Frank Holecek and the patient, as most suitable

Length of Treatment: ☐ 99 Years (Lifetime). ☐ Other (Specify): ____________________.

Notes: ____

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Signature of Referring Physician: ____

As a physician, I deem this therapy to be medically necessary.

Date: ____________________

* Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician. Oral Appliance Therapy (OAT) is less effective in controlling severe sleep apnea than C-PAP, and patient referred for this therapy may need to explore additional options of treatment if the appliance alone is deemed to provide suboptimal management of the sleep apnea. Copies of sleep studies with full report are required by Dr. Holecek for appropriate care and to obtain medical coverage.