Oral Appliance – Medical Necessity DME Medical Review Form

A. To be completed by a health professional (MD, NP, PA) - not vendor (dentist).
B. When completed, health professional faxes to vendor (dentist), who submits to CoOportunity Health.

Quality and Utilization Improvement Dept	**Telephone # (888) 467-0774**
DME - Medical Policy	**Fax # (952) 853-8714**

Please answer the following questions. This information is REQUIRED in order to determine if member meets coverage criteria.

Member name:	Date of birth:	Member ID #
Completed by:	Phone #	Fax #:
MD Ordering (print first & last name)		
MD Phone #:	MD Fax #:	

ORAL APPLIANCE - MEDICAL NECESSITY

1. Date of Obstructive Sleep Apnea (OSA) clinical evaluation:______________________
2. Type of sleep testing done to confirm diagnosis of OSA:
   a. Portable home sleep test
   Type II_____ Type IIII______ Type IV_____ Other (list device name) _____________________
   Date home sleep test completed: ________________________________

   OR

   b. Polysomnography
   Date of service________________ Facility ____
3. Diagnosis of OSA/UARS is confirmed by sleep test: Yes_______ No_______
4. The sleep test must document one of the following A-C (please check one):
   A. *Mild sleep apnea* - the AHI or RDI is > or = to 5 events/hour and < or = 14 events/hour ___________
   B. *Moderate sleep apnea* - the AHI or RDI is > or = to 15 events/hour and < or = 30 events/hour ________
   C. *Severe sleep apnea* - the AHI or RDI is > 30 events/hour ________
5. If diagnosis is severe sleep apnea, a *sleep specialist must evaluate and recommend oral appliance - (*sleep specialist must be a physician, as defined in the Oral appliance policy)
   Name of *sleep specialist: ____
   Name of *sleep specialist practice group: ____
6. Treatment with CPAP (must select at least one):
   Not a candidate_______ Unsuccessful _______ Intolerant_______ Refuses________
7. Is CPAP being used in addition to the oral appliance? Yes_______ No_______
8. If yes, please explain medical reason for both types of treatment being used at the same time:
   ____
   ____
9. Additional Information:
   ____
   ____

I confirm that the information above is correct.
Health provider signature (not dentist): _____________________________________ Date: ______________

For candidates with severe sleep apnea, treatment with an oral appliance requires either the sleep specialist's signature below, or the sleep specialist's written recommendation must be submitted with this request form:

I confirm that the information above is correct.
Sleep specialist provider signature: _______________________________ Date: ______________

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