



Washington
Center for
Sleep

Nick Koogler DDS
40 Lake Bellevue Dr.
Suite 250
Bellevue WA 98005
Tel: 425-209-0700
Fax: 425-437-3497

Sleep Records Request

Attention: _____

Patient: _____

DOB: _____

Our office is requesting the following patients records in order to submit them to insurance for pre-authorization for their oral sleep appliance.

1. Pre-Sleep Study MD Notes
2. HST/PSG Results
3. Post-Sleep Study MD Notes
4. Oral Appliance Therapy Prescription (attached)

Please fax these documents to 425-437-3497

Thank you,

Nick Koogler DDS D.ABDSM



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PRESCRIPTION FOR ORAL APPLIANCE THERAPY FOR OBSTRUCTIVE SLEEP APNEA

PATIENT INFORMATION

Name

Phone DOB

Insurance Carrier ID Number

REFERRING INFORMATION

Referring Provider

Phone Fax

DIAGNOSIS

Snoring (R06.83)

Obstructive Sleep Apnea (G47.33) Severity

CPAP TREATMENT

CPAP Intolerant

Not a candidate for CPAP Therapy

AS A PHYSICIAN I DEEM THIS TREATMENT MEDICALLY NECESSARY

Provider Signature Date

**Please fax or email this prescription to our office
and keep a copy for your records**