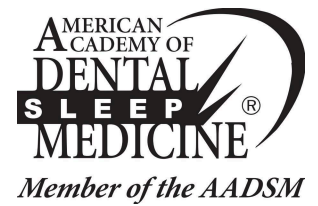


Dr. Adam Altdorfer, AADSM Qualified Dentist
1933 28th St, STE 204
Boulder, CO 80301
PH: 720-645-1226 FAX: 888-424-7388
info@sleepbetterapneatherapy.com



Welcome! Let's Get Started

Thank you for your interest in snoring and sleep apnea solutions at Sleep Better Apnea Therapy!

We would like to warmly welcome you and provide an introduction to what you may expect during your visit to our office.

At your initial evaluation, Dr. Adam will review a sleep screening questionnaire with you. He will do a sleep focused dental examination, inform you about obstructive sleep apnea and its consequences and discuss treatment options that may include oral appliances.

Diagnosis of obstructive sleep apnea and any treatment is only arranged through your primary care physician or sleep certified medical specialist. Dr. Adam works with your providers to get you the proper care that you need and desire.

Our team is dedicated to making your visits to our office comfortable and educational. We pride ourselves in meeting the individual needs of each patient. We strive to provide state of the art services in dental sleep medicine. Dr. Adam is an American Academy of Dental Sleep Medicine Qualified Dentist, and is passionate about helping patients get better sleep and live better lives. Communication is important to us, so feel free to ask questions about treatment alternatives, fees, or new procedures in sleep medicine and dentistry.

Our office uses state of the art technology and offers industry-leading oral appliance brands for providing successful therapy. We are a participating provider for most major medical insurance companies and will attempt to bill your medical insurance for your appointments even if we are out of network.

Once again, a hearty welcome! We look forward to seeing you at Sleep Better Apnea Therapy.

Yours in "better life through better sleep",

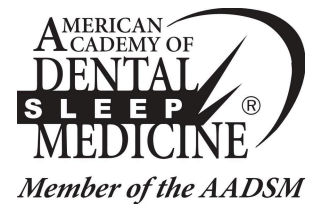
Dr. Adam and The Sleep Better Apnea Therapy Team

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Patient Instructions

Getting Ready For Your First Appointment at Sleep Better Apnea Therapy

Here is what we will need to have in hand to get started.

Your doctor will need to provide us with:

1. Letter of Medical Necessity (included in the Physician's Guide Packet), and
2. Copy of Diagnostic Sleep Test < 3 years old

If you have not been diagnosed with OSA, or if you have not had a sleep test in the previous 3 years, please contact your physician for evaluation or to update your records.

Your dentist will need to provide us with:

1. Your current dental records, and
2. verification of up to date dental care
(included in the Dental Records Request and Dental Care Verification packet)

If you have not seen your dentist in the last six months for an exam, please contact your dentist to schedule an exam to update your records. Otherwise we can schedule extra time during your appointment with us to complete a dental examination and take any x-rays that are required.

After we receive the above documents from your doctor and dentist, we will call you for an appointment to address your desires about oral appliance therapy.

Complete before your first appointment (these will be emailed to you when you are ready to schedule)

- Registration forms, Medical History, CPAP Affidavit, Sleep Questionnaires and Treatment Consent Form

Bring to your first appointment:

- Your medical insurance card
- A photo ID

At your first appointment Dr. Adam will:

- Verify that you are a good candidate for oral appliance therapy for Sleep Apnea
- Answer any questions you have about sleep apnea or oral appliance therapy
- Examine your mouth
- Take the records necessary to fabricate your appliance if you decide to proceed
- Discuss your insurance coverage or copayment
- Collect any appropriate copayment or down payment for your appliance

*Your medical insurance will be billed for this appointment

Getting Started:

Simply bring the "Physician's Guide" packet to your doctor and the "Dental Records Request and Dental Care Verification" packet to your dentist. They have clear instructions for them to complete the necessary forms for us to proceed with oral appliance therapy for you and to bill your medical insurance or Medicare. Sleep Better Apnea Therapy will do all medical billing for you. We look forward to seeing you soon! Upon receipt of the necessary documents from your physician, we will contact you to set up your first appointment. Feel free to contact us at any time to check on the status of your necessary records.

Benefits Of Oral Appliance Therapy In Obstructive Sleep Apnea

Oral appliance therapy (OAT) is a front-line treatment for patients with mild to moderate Obstructive Sleep Apnea (OSA) who prefer OAT to continuous positive airway pressure (CPAP), or who do not respond to CPAP, are not appropriate candidates for CPAP, or who fail treatment attempts with CPAP or treatment with behavioral measures such as weight loss or sleep position change. This small plastic device fits in the mouth during sleep like a sports mouth guard or orthodontic retainer. Oral appliances help prevent the collapse of the tongue and soft tissues in the back of the throat, keeping the airway open during sleep and promoting adequate air intake. Oral appliances may be used alone or in combination with other treatments for sleep related breathing disorders, such as weight management, surgery or CPAP.

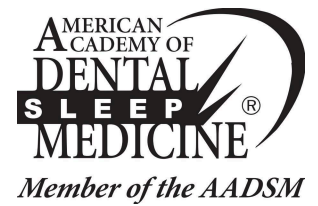
Oral appliance therapy offers many of the same health benefits as CPAP. By treating your sleep apnea, you can **reduce your risk for heart disease*, stroke and diabetes**. You will also improve your **daytime alertness, concentration and emotional stability**.

The additional benefits of oral appliance therapy include:

1. **Comfortable and easy to use** - Some patients prefer oral appliances because they can be easy to wear and are more comfortable than alternatives like CPAP. For most patients it takes a few weeks to get used to sleeping with an oral appliance in their mouth.
2. **Small and easy to transport** - Traveling with your sleep apnea treatment is easy with an oral appliance for OSA. Unlike CPAP, oral appliances are small enough to fit in your purse or carry-on bag.
3. **Reduced cost** - Non recurring costs for disposables, masks, or monthly fees like CPAP.
4. **Reversible, non-invasive treatment** - Unlike surgery, oral appliance therapy can be discontinued at any time.
5. **Increases the muscle tone of the tongue** - to help in improving the airway during daytime hours without the appliance in.
6. **Compliance with oral appliances is high** - because people like them and wear them. Up to 50% of people with CPAP report that they do not like the CPAP or are unable to wear it.

* Van Haesendonck G, Dieltjens M, et.al. Cardiovascular benefits of oral appliance therapy in obstructive sleep apnea: a systematic review. Journal of Dental Sleep Medicine 2015;2(1):9-14.

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Physician's Guide

To Oral Appliance Therapy in Management of Obstructive Sleep Apnea

Your patient has contacted us in regard to fabricating them an oral appliance for OSA.

Our mutual goal is to get them adequate oxygen during sleep, all the time.

The AASM recognizes that oral appliances can be an effective treatment in many mild and moderate OSA patients and an option in severe cases where the patient is CPAP intolerant.

"Back Into CPAP"

Patients who are CPAP intolerant because of high air pressures often benefit from hybrid therapy - where the oral appliance allows them to get back into their CPAP by opening their airway and allowing CPAP use at a lower, more comfortable pressure. Our intention is to get patients back into their CPAP if this is what they need for full treatment.

After their custom oral appliance is fabricated and adjusted symptomatically and confirmed through pulse oximetry, you will be asked to order a titration sleep study to confirm efficacy. The sleep technician will titrate the appliance to full treatment or add a small amount of CPAP if indicated or tolerated.

There are only 2 things you need to send us:

- 1. Letter of Medical Necessity (included in this packet), and**
- 2. Copy of Diagnostic Sleep Test <3 years old.**

If your patient has not been diagnosed with OSA, or if they have not had a sleep test in the previous 3 years, please contact them for evaluation or to update their records.

After we receive the 2 documents from you, we will contact your patient and proceed with oral appliance therapy. You will receive updates on your patient's progress.

Thank you for being involved in your patient's desire to have full treatment for their OSA. Feel free to contact us if you have any questions about their care.

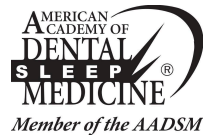
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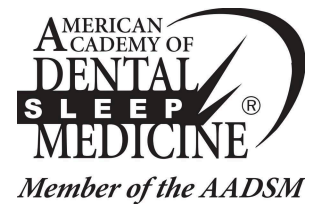


Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea
And Letter of Medical Necessity Form

In order to facilitate prompt insurance reimbursement for our mutual patient, please sign and fax or email this form with a copy of the **most recent diagnostic sleep test results** (if available) to the office address listed at the top of this document. Once the sleep apnea appliance is in place, a follow-up study will be required to validate the efficacy of treatment. We will contact your office to have you arrange this for the patient.

PRESCRIBING PHYSICIAN INFORMATION			
Name:	NPI:	License#:	
Phone:	Address:	City:	Zip:
PATIENT INFORMATION			
Name:	DOB:	Gender (assigned at birth):	
Insurance Company:	Group No:	Account/ID No:	
Phone:	Address:	City:	Zip:
PRESCRIPTION INFORMATION			
CODE - E0486 (Quantity: 1) Prescription to be filled by: Adam Altdorfer, DDS - Sleep Better Apnea Therapy			
The patient referred with this form has been evaluated by the above physician and has been diagnosed, using acceptable medical criteria, to have: (CHECK ALL THAT APPLY)			
Primary Diagnosis:			
<input type="checkbox"/> ICD 10 G47.33-Obstructive Sleep Apnea			
<input type="checkbox"/> ICD 10 G47.30-Upper Airway Resistance Syndrome			
<input type="checkbox"/> ICD 10 G47.30-Hypersomnolence w/Sleep Apnea (Excessive Daytime Sleepiness)			
<input type="checkbox"/> ICD 10 G47.30-Insomnia w/ Sleep Apnea			
<input type="checkbox"/> ICD 10 G47.61-Sleep-Related Limb Movement			
<input type="checkbox"/> ICD 10 R06.83-Snoring			
Secondary Diagnosis (Comorbidities): _____			
Apnea Hypopnea Index (AHI): _____			
Minimum Oxygen Saturation (SpO2 Nadir): _____ Respiratory Disturbance Index (RDI): _____			
Date of Last Diagnostic Sleep Test: _____ Date of Titration Sleep Test: _____			
*REQUIRED- CHECK ONE BELOW FOR INSURANCE COVERAGE:			
<input type="checkbox"/> *The patient prefers OAT over CPAP or surgical alternatives for Mild or Moderate OSA.			
<input type="checkbox"/> *The patient is CPAP intolerant or non-compliant .			
<input type="checkbox"/> *The patient requires combination therapy of OAT in conjunction with CPAP.			
<input type="checkbox"/> *The patient is not a candidate for CPAP Therapy.			
Explanation (if necessary): _____			
Duration of PAP Treatment:			
Start Date _____ End Date _____ Still Currently Using _____ Yes _____ No			
MEDICAL NECESSITY VERIFICATION AND PRESCRIPTION AUTHORIZATION			
As the patient's treating physician, I deem this therapy to be MEDICALLY NECESSARY.			
PHYSICIAN'S SIGNATURE: _____		DATE: _____	
<i>Statement of medical necessity: The above patient had a sleep-disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an ORAL APPLIANCE is medically necessary. Currently, Medicare has a code (E0486) with the following descriptor, "ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS" Treatment duration will be at least one year and could be required for the remainder of the patient's life. If you should have any questions, please contact the prescribing physician.</i>			

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Dental Records Request and Dental Care Verification

For Oral Appliance Therapy in Management of Obstructive Sleep Apnea

Your patient has contacted us in regard to fabricating them an oral appliance for OSA.

We are reaching out to collect their current dental records and radiographs, and to confirm completed dental treatment for this patient. We would like to avoid unnecessary exposure and expenses to the patient if current radiographs are available. We also want to ensure that they have had a dental exam with you in the last six months, that their dentition and periodontium are in healthy condition and that they have completed all recommended dental treatment with you before proceeding with oral appliance therapy in order to avoid future complications and expenses. Please fax or email the following to us attached to this form.

Here is what we would like you to send us (please check off what is being attached and returned to us):

- **Complete Dental Charting**
- **Complete Periodontal Charting (with date)**
- **High Resolution PAs and BWs exposed within the last year (with dates)**
- **High Resolution FMX and Panoramic X-rays exposed within the last five years (with dates)**

After their custom oral appliance is fabricated the patient will be referred back to you for their continued regular dental care. In the event that any major dental procedure needs to be completed after oral appliance delivery, please inform us so that we may collaborate with management of their oral appliance as needed. It is very important that they are able to wear their appliance at all times. Please do not adjust their oral appliance to avoid voiding the warranty on the device. Instead, please have the patient contact us for any device management related requests.

Thank you for being involved in your patient's desire to have oral appliance therapy treatment for their OSA. Feel free to contact us if you have any questions about their care.

Patient Name: _____ **DOB:** _____

As the patient's treating general dentist, I am forwarding all available requested records as indicated above for the patient named on this form. I hereby verify that the patient is up to date with their recommended dental care at this time OR, in the case that the patient has not completed all recommended treatment, I hereby verify that the patient has been made aware of their outstanding dental treatment recommendations and potential risks to not completing the recommended treatments.

Dentist Name: _____

Dentist Signature: _____ **Date:** _____