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2737 S. Embers Lane T (773) 885-7686 F (773) 283-8660
Arlington Heights, IL 60005

FAX REQUEST FOR HEALTH INSURANCE PRE-ESTIMATE FOR SLEEP APNEA ORAL APPLIANCE

Please FAX completed form to: (773) 283-8660

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

Address: _____ City: _____

State: ____ Zip Code: _____ Cell Phone #: _____

Email: _____ Home phone #: _____

Health Insurance Name: _____

ID# _____ Group# _____

1. **Has this patient ever used a CPAP? (If No, skip 2 and 3)** **Yes** **No**
2. **If yes:**
   Do you have a copy of the sleep study report? If yes, please attach. **Yes** **No**
3. **If no:**
   Should we contact the patient / lab to get a copy of the sleep study report? **Yes** **No**

Dentist Name: _____

Practice Name: _____

Address: _____

Phone: ( ) _____ Fax: ( ) _____

Email: _____

Tax ID#: _____ NPI #:_____

PLEASE FAX THIS COMPLETED FORM TO: 773-283-8660