SLEEP WELL

Southeast Texas

LETTER OF MEDICAL NECESSITY AND RX

Patient Name: ____

Date of Birth: ____

Insurance ID Number: ____

Re: Obstructive Sleep Apnea and Mandibular Advancement
Device Rx and Statement of Medical Necessity

I am prescribing a custom fabricated Mandibular Advancement Device Therapy with an Oral Appliance (E0486) with a fixed mechanical hinge (K1027) w/o fixed mechanical hinge as the initial replacement therapy for the above patient. The patient named above has been diagnosed with Obstructive Sleep Apnea (G47.33) and has a documented intolerance or refusal to use a CPAP. I concur that the recommended therapy is medically necessary and I now prescribe treatment utilizing an FDA-approved device as indicated above.

The make of the device indicated is: ____

And the model: ____

The billable fee associated with the device is: $__________________________________

The length of need for treatment is a lifetime. I strongly urge you to cover the cost of this therapy. Failure to do so would jeopardize the patient's overall health and life. Accept this as documentation from the best physician (MD) for treating the diagnosed condition of OSA.

______________________________________	____________________
Physician Printed Name	Physician NPI
______________________________________	____________________
Physician Signature	Date