Letter of Medical Necessity / Rx for Oral Appliance Therapy for Obstructive Sleep Apnea and Bruxism

Physician Name: _____

NPI Number: _____

Address: _____

Phone Number: _____

Patient Information

Name: _____ Age: _____

DOB: _____ Gender: M F Test Date: _____

PATIENT NAME has been diagnosed by a Board-Certified Sleep Physician with Obstructive Sleep Apnea (G47.33) and Bruxism and has recommended Custom Oral Dental Device (E0486) titrated to optimal therapeutic position. This patient has signed a CPAP intolerance form.

- Unspecified Sleep Apnea (G47.30)
- Snoring (R06.83)
- Nocturnal Bruxism (G47.63)
- Hypersomnia Unspecified (G47.30)
- Obstructive Sleep Apnea (G47.33)

LETTER OF MEDICAL NECESSITY FOR OBSTRUCTIVE SLEEP APNEA ORAL APPLIANCE THERAPY

The above referenced patient has an absolute Medical Necessity for sleep apnea. I certify that the above-prescribed oral appliance are medically indicated and in my opinion is reasonable and medically necessary with reference to the standards of medical practice for this patient's condition. The duration of the prescribed appliance therapy is lifetime unless other indicated.

Prescription:

· Trial of a custom oral appliance titrated to manage OSA

· Use nightly while sleeping

In the absence of any diagnosed medical co-morbidities such as Central Sleep Apnea or congestive heart failure or any other medical condition known to be contraindicated, I prescribe the above listed therapy.

_____, MD