COMPLETE HEALTH
SLEEP SoCal
Erela Katz Rappaport, DMD, D-ABDSM

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LETTER OF MEDICAL NECESSITY (LOMN) AND Rx

Order Date : _____

Patient Name: _____

Date of Birth : _____

Patient is being referred for an evaluation for:

☐ Oral Appliance Therapy ☐ HST ☐ Consultation ☐ Myofunctional Therapy

Re: Obstructive Sleep Apnea and Mandibular Advancement Device
Rx and Statement of Medical Necessity
I am prescribing a Mandibular Advancement Device **(E0486)** for the above-named patient who has been diagnosed with Obstructive Sleep Apnea **(G47.33)**. I concur that the recommended therapy is medically necessary, and I now prescribe treatment utilizing an FDA approved Mandibular Advancement Device. Length of need is lifetime. I strongly urge you to cover the costs of this therapy. Failure to do so would place the patient's health in jeopardy.

Prescribing Physician (PRINT): _____ NPI: _____

Prescribing Physician's Signature: _____ Date: _____

Physician Address: _____

Phone: _____ FAX: _____