kellerman dental

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LETTER OF MEDICAL NECESSITY (LOMN) AND Rx

Patient Name: _____

Date of Birth: _____

ID Number: _____

Re: Obstructive Sleep Apnea and Mandibular Advancement Device

Rx and Statement of Medical Necessity

I am prescribing a Mandibular Advancement Device (**E0486**) as initial/replacement treatment forthe 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 (MAD).

The make of the MAD is: _____

and the model: _____

The billable fee associated with the MAD treatment is $: _____

The 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.

Physician's Name: _____

Physician's Signature: _____

Date: _____

Physician Address: _____

_____