

# LETTER OF MEDICAL NECESSITY (LOMN) AND Rx

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## 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.

Physician Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Address: \_\_\_\_\_

\_\_\_\_\_