P: 940-498-2264
F: 940-498-2366
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DFW SLEEP SOLUTIONS

Letter of Medical Necessity and Prescription for Oral Appliance Therapy

Referring Physician: _____ Tel: _____

Patient Name: _____

Patient Address: _____

Patient Telephone: _____

Please fax a copy of the patient's medical insurance card and sleep study with this prescription. Along with the 3 most current clinical notes from the patient's last visits.

Prescription to be filled by:

Suzanne Thai, DDS
DFW Sleep Solutions 3941
FM 2181 Corinth, TX
76210

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

☐ Obstructive Sleep Apnea (G47.33) Severity: _____
-or-
☐ Simple Snoring

This patient is:

☐ Intolerant of C-PAP therapy ☐ Is not a candidate for C-PAP therapy

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.

Signature of Referring Physician: _____

NPI # _____

Date: _____ *As a physician, I deem this therapy to be medically necessary.*

Please fill out this prescription in its entirety.

*Obstructive Sleep Apnea Is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.