Dental Sleep Medicine Of Greenville

LOMN/RX and Statement of Medical Necessity

Referring Physician: _____ Tel: _____

Patient Name: _____

Patient Address: _____

Patient Telephone: _____

*Please fax copy of patient's medical insurance card and sleep study with this prescripton.

Prescription to be filled by:

☐ Dental Sleep Medicine of Greenville
40 Pointe cir,
Greenville, SC 29615

☐ Need Home Sleep Study Test

☐ TMJ Evaluation

☐ OSA Appliance

The patient referred with this from 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 (EO 486) for the above named patient who has been diagnosed with Obstructive Sleep Apena (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 Physican: _____

DR. NPI # _____

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

Please fill out this prescription in its entirely.

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