Letter of Medical Necessity

Patient Name: _____ Date of Birth: ____/____/____
Last First

Home Phone: (___)____-_____

Diagnosis: Length of Need:

Respiratory Disturbance Index (RDI): _____ Apnea Hypopnea Index (AHI):____

Lowest Desaturation (SpO2): _____ Percent of Time Below 90%: _____

Comments / Special Instructions:

Statement of Medical Necessity

The above patient had undergone a sleep disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea. _____ has tried to use the prescribed CPAP therapy and is intolerant to CPAP. The evaluation confirmed that an ORAL APPLIANCE is medically necessary.

Treatment duration will be at least one year, unless other interventions such as surgery occur, and could well be required for the remainder of your subscriber's life. ORAL APPLIANCE is used as an alternative to surgery and/or CPAP. If you should have any questions, please contact the prescribing physician.

DR _____ Date: _____/_____/_____