Patient ID:____________________ Date:______________

If the patient is diagnosed with obstructive sleep apnea and is then prescribed oral appliance therapy, please return this form. FAX TO: 855-475-5638

Referring provider:__________________________________ Clinic name: ___________________________

Address: ____

Phone: ______________________________________ Fax: ____

PRESCRIPTION FORM / LETTER OF MEDICAL NECESSITY (LOMN) FOR ORAL APPLIANCE THERAPY CODE – E0486, QUANTITY-1

Patient information

Patient name:____ DOB: _________ Age: _________

Patient address: ____

Phone: ______________________ Insurance company: ____

Insurance ID#: ____

Physician information/Diagnosis

Prescribing physician:____ NPI#: _______________

Primary diagnosis: ☐ G47.33 (Obstructive Sleep Apnea)

Secondary diagnosis: ____

Duration of treatment: ____

Description of oral appliance: *Oral appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabrication and includes fitting and adjustments.*

Additional physician remarks:

Treatment orders (Please check)

☐ Mandibular advancement device for treatment of OSA

☐ Mandibular advancement device to be used in combination with CPAP for treatment of OSA

☐ Other: ____

Statement of medical necessity: The above patient has a sleep-disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an ORAL APPLIANCE is medically necessary. Currently, Medicare has a code (E0486) with the following descriptor, "ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION, INCLUDES FITTING AND ADJUSTMENTS". Treatment duration will be at least one year and could be required for the remainder of the patient's life.

Physician signature: ____ **Date:** ____________

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