

Prescription form / Letter of Medical Necessity
LOMN for Oral Appliance Therapy
Code – E0486 - Date : __ / __ / __

Should the patient be diagnosed with obstructive sleep apnea or snoring and be prescribed oral appliance therapy, Please fill this form and fax to : 330-591-4088

Referring Provider :

Dr . Sailaja Reddy BDS, DMD, Diplomate, ABDASM
Medina Dental Sleep Solutions
Phone no : 330-667-4442 FAX No : 330-591-4088
Address : 3617 Reserve Commons Dr, Medina , OH 44256

Patient Name : _____ **DOB:** _____

Patient Phone No : _____

Patient intolerant to CPAP : _____ **Patient not a candidate for CPAP:** _____

Prescribing Physician : _____

NPI : _____

Primary Diagnosis : __ G47.33(Obstructive sleep apnea) __ R06.83(Snoring)

Secondary Diagnosis: _____

Duration of Treatment : _____

Additional Physicians Remark : _____

PHYSICIAN SIGNATURE : _____ **Date :** _____

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 description – ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE, CUSTOM FABRICATION AND INCLUDES FITTINGAND ADJUSTMENTS—Treatment duration will be at least one year and could be required for the remainder of the patients life. I strongly urge you to cover the costs of this therapy. Failure to do so would put the patient's health in jeopardy. If you should have any questions, please contact the prescribing physician.