MAGNOLIA
sleep solutions

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Letter of Medical Necessity (LOMN) and Rx

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Phone:** _____

Re: Obstructive Sleep Apnea and Mandibular Advancement Device Rx and Statement of Medical Necessity

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

___ Obstructive Sleep Apnea G47.33

I am prescribing:

_____ Mandibular Advancement Device (E0486)

As the initial/replacement therapy for the above-named patient who has been diagnosed with Obstructive Sleep Apnea (G47.33) and their documented intolerance or refusal to use CPAP. I concur that the recommended therapy is medically necessary and I now prescribe treatment utilizing an FDA approved device indicated above.

Patient is being referred for E0486 MANDIBULAR ADVANCEMENT DEVICE THERAPY with:

____ Appliance chosen as most suitable by Magnolia Sleep Solutions and the patient.

As a Physician, I deem this therapy to be medically necessary.

_____ _____
Physician Printed Name Physician NPI

_____ _____
Physician Signature Date

_____ _____
Physician Address Phone

Date of last sleep study _____ **____ Copy Enclosed**

Please fax or e-mail the completed form to (225-267-4158) or magnoliasleepdds@gmail.com

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