LETTER OF MEDICAL NECESSITY

PRESCRIPTION FOR ORAL APPLIANCE THERAPY

PATIENT:_____

DOB:_____

INSURANCE:_____

ID NUMBER:_____GROUP NUMBER:_____

RE: Obstructive Sleep Apnea and Oral Appliance Therapy

Date:_____

To Whom it May Concern,

_____ is under my care for Obstructive Sleep Apnea (OSA), a diagnosis confirmed by a sleep study dated_____. Patient scored an AHI of _____. The patient has not been unable to tolerate CPAP effectively.

I believe the patient is a good candidate for an Oral Appliance. I have referred to **Dr Kelvin Chye**, local dentist who have training in the treatment of patients with OSA with the use of oral appliance therapies. The device that I have prescribed is for the treatment of the patient's OSA, a medical condition, and NOT for any dental disorder.

As you are well aware, OSA with an AHI of 10 or higher merits therapy due to the cardiovascular consequences alone. Failure to treat would be gross negligence. I strongly urge you to cover the costs of this therapy. Failure to do so would place this patient's health in jeopardy.

Sincerely,

_____

Physician's Name

Physician's Signature:_____