CALIFORNIA DENTAL SLEEP SOLUTIONS

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LETTER OF MEDICAL NECESSITY & Rx

TRANSMITTED VIA **email** ☐ coordinator @ cadentalsleep.com
fax ☐ (408) 578 - 7127

Patient Name _____ DOB _____ Ht_____ Wt_____

Patient Address _____ Sleep Study Date _____

Primary Phone _____ AHI _____

Secondary Phone _____ RDI _____

Email _____ CPAP Pressure _____

Diagnosis

Obstructive Sleep Apnea (G47.33) ☐ Severity: _____

Upper Airway Resistance Symptoms ☐

Narcolepsy ☐

Periodic Limb Movement Disorder ☐

Restless Leg Syndrome ☐

Snoring ☐

Addt'l _____

Notes:

CPAP Tolerance

N/A ☐

Intolerant of CPAP ☐

Intolerant of Mask ☐

Intolerant of Pressure ☐

Skin Sensitivity ☐

Claustrophobia ☐

Not a CPAP Candidate ☐

Treatment Orders

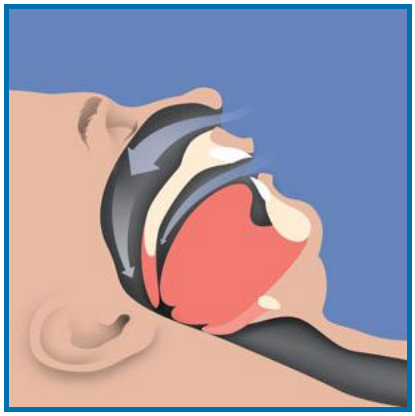
The patient has been evaluated and diagnosed with Obstructive Sleep Apnea (G47.33) by the referring physician. The physician recommends an FDA approved Mandibular Advancement Device (E0486) as treatment. I, the undersigned physician, certify the medical necessity of the prescribed treatment of the sleep disorder diagnosis. Duration of necessity may be lifetime.

Mandibular Advancement Device (E0486) ☐ In Combination with CPAP ☐

Referring Physician Name _____ Physician Signature _____

Physician NPI# _____ Date _____

Obstructed Airway



Mandibular Advancement Device

Airway Restored