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NEW CONCEPT SLEEP REFERRAL

Fax to 855 295 7042

Patient's Name:

DOB:

Phone Number:

Diagnosis of OSA (G47.33)? YES _____ NO _____

- Please send:**
- Demographics
 - Baseline Sleep Study Report
 - Face to Face notes prior the Sleep Study

LETTER OF MEDICAL NECESSITY

The above patient has been diagnosed with Obstructive Sleep Apnea (G47.33). I am prescribing treatment for the diagnosis with a Mandibular Advancement Device (E0486). The prescribed Mandibular Advancement Device is FDA cleared. I certify that the recommended treatment is medically necessary. The duration of treatment for this disease is for the lifetime of the patient. Quantity required is one and the standard repair and replacement policies outlined by the patient's insurance plan should be followed.

Physician Name: _____

Physician Signature: _____ NPI: _____

Date: _____

Referring office phone #: _____ fax # _____