LETTER OF MEDICAL NECESSITY (LOMN) AND Rx

PATIENT NAME:

PATIENT DOB:

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

I am prescribing a Mandibular Advancement Device (E0486) as initial or replacement therapy for the above-named patient, who has been diagnosed with Obstructive Sleep Apnea (ICD-10: G47.33).

Based on the patient's diagnosis and clinical presentation, I concur that treatment with a mandibular advancement device is medically necessary. I am prescribing an FDA-approved Mandibular Advancement Device (MAD) to manage the patient's condition effectively.

The specific model of the MAD will be selected based on clinical findings and patient needs, and may include:

- EVO – Iterative Advancement
- Avant – Iterative Advancement
- LP – Continuous Advancement
- Dual Arm – Precision Herbst (Medicare approved)

Length of need: Lifetime

I strongly urge that coverage be provided for this therapy. Denial of coverage may place the patient's health and well-being at serious risk.

Physician's Name: _____

Physician's Signature: _____

Date: _____

Physician Address: _____

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