LETTER OF MEDICAL NECESSITY (LOMN) AND Rx

Patient Name:	
Date of Birth:	
ID Number:	
Re: Obstructive Sleep Apnea and Mandibular Advancement Device	
Rx and Statement of Medical Necessity	
I am prescribing a Mandibular Advancement Device (E0486) for the above named pabeen diagnosed with Obstructive Sleep Apnea (G47.33). I concur that the recommen medically necessary and I now prescribe treatment utilizing an FDA approved Mandib Advancement Device. Length of need is lifetime. I strongly urge you to cover the cost therapy. Failure to do so would place the patient's health in jeopardy.	nded therapy is oular
Physician Name:	
Physician's Signature:	
Date:	
Physician Address:	
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