

P: 512-215-4350

F: 512-647-6367



LOMN/RX and Statement of Medical Necessity

Referring Physician: \_\_\_\_\_ Tel: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Telephone: \_\_\_\_\_

\*Please fax copy of patient's medical insurance card and sleep study with this prescription.

Prescription to be filled by:

Sleep Better Austin - South
5920 W. William Cannon Dr.
Bldg #6, Suite 210
Austin, TX 78749

Sleep Better Austin - Cedar Park
920 N. Vista Ridge Blvd.
Suite 700
Cedar Park, TX 78613

Sleep Better Austin - Central
The Jefferson
1600 W. 38th St., Suite 407
Austin, TX 78731

Sleep Better Austin - Georgetown
4405 Williams Dr.
Suite 300
Georgetown TX 78628

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

- Obstructive Sleep Apnea ( G47.33 ) Severity: \_\_\_\_\_
-or-
 Simple Snoring

This patient is:

- Intolerant of C-PAP therapy  Is not a candidate for C-PAP therapy

I am prescribing a Mandibular Advancement Device ( EO 486 ) for the above named patient who has been diagnosed with Obstructive Sleep Apnea ( G47.33 ). I concur that the recommended therapy is medically necessary and I now prescribe treatment utilizing an FDA approved Mandibular Advancement Device. Length of need is lifetime. I strongly urge you to cover the costs of this therapy. Failure to do so would place the patient's health in jeopardy.

Signature of Referring Physician: \_\_\_\_\_

DR. NPI # \_\_\_\_\_

Date: \_\_\_\_\_ As a physician, I deem this therapy to be medically necessary.

Please fill out this prescription in its entirety.

\*Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.