



SLEEP APNEA —SOLUTIONS—

Dr. Rachelle Brown, DDS

11920 College Blvd, Overland Park, KS 66210
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Phone: 913.400.2150 | Fax: 913.210.5661
Email: sleep@sleepapneakc.com
Website: <https://sleepapneakc.com/>

Date: _____

Patient Name : _____

Patient DOB : _____

Patient Phone : _____

Patient E-Mail : _____

Referring Doctor : _____

Referring Dr's Phone/Fax : _____

Medical Insurance Provider : _____ Medical Insurance ID : _____

Patient is being referred for an evaluation for Oral Appliance Therapy

HST/ PSG Date: _____

Diagnosis : OSA Mild Moderate Severe

Patient currently uses a CPAP : Yes No

Patient declined CPAP and contraindication is noted or is CPAP intolerant : Yes No

Comments : _____



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LETTER OF MEDICAL NECESSITY (LOMN) AND Rx

Order Date : _____

Patient Name : _____ Date of Birth : _____

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 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.

Prescribing Physician (PRINT) : _____ NPI : _____

Prescribing Physician's Signature : _____ Date : _____

Physician Address : _____

Phone : _____ FAX : _____

