Meridian Office: (208) 900-8686

Pocatello Office: (208) 648-4908

FAX ALL REFERRALS TO: (888) 388-0608

LETTER OF MEDICAL NECESSITY AND Rx

Referring Physician:_____**Phone**:_____

Patient Name:_____**DOB**:_____

Patient Address:_____

Patient Phone:_____

**Please fax copy of patient's medical insurance card, sleep study, & most recent visit clinical notes with this prescription.*

Prescription to be filled by:

☐ Sleep Better Idaho – Meridian
3200 N. Leslie Way, #100
Meridian, ID 83646

☐ Sleep Better Idaho – Pocatello
1246 Yellowstone, B3
Pocatello, ID 83201

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 ☐ Not a candidate for C-PAP therapy

I am prescribing a *Custom Fabricated Oral Appliance 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 *Custom Fabricated Oral Appliance 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:_____

NPI #: _____

Date:_____ As a physician, I deem this therapy to be medically necessary. Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.