9370 SW Greenburg Rd
Suite 422 Portland, OR 97223

SLEEP HEALTH PARTNERS

Office: 971-339-0186
Fax: 971-339-0824
HIPAA-Compliant Email:
info@sleephealthpartners.com

Alamin Karim, DDS, D.ABDSM

LETTER OF MEDICAL NECESSITY (LOMN) AND Rx

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**), used to reduce upper airway collapsibility, 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.

Diagnostic sleep study date (within the last 2 years):_____ 3% AHI _____

4% AHI _____ RDI _____ O2 nadir _____ Time below 90% (percent or amount) _____

Patient is: ____ Intolerant of CPAP Therapy ____ Is not a candidate for CPAP Therapy

Comorbid conditions:

____ Hypersomnia ____ Insomnia ____ Impaired cognition ____ Hypertension

____ Anxiety/Depression ____ Heart Disease ____ History of stroke ____ ADD/ADHD

____ Other: _____

Prescribing Physician: _____ NPI: _____

Physician Signature: _____ Date: _____

Business Name: _____

Physician Address: _____

Phone: _____ FAX: _____

Better Sleep For a Brighter Tomorrow

Please provide the following items with your referral:

□ Insurance information (Please attach face sheet if available)

□ Chart notes pre and/or post-sleep study, including problem list.

□ Diagnostic Sleep Study within the last 2 years. If none is available, please include an Rx.