

**LETTER OF MEDICAL NECESSITY
PRESCRIPTION FOR ORAL APPLIANCE THERAPY**

PATIENT: _____

DOB: _____

INSURANCE: _____

ID NUMBER: _____ GROUP NUMBER: _____

RE: Obstructive Sleep Apnea and Oral Appliance Therapy

Date: _____

To Whom it May Concern,

_____ is under my care for Obstructive Sleep Apnea (OSA), a diagnosis confirmed by a sleep study dated _____. Patient scored an AHI of _____. The patient has not been able to tolerate CPAP effectively.

I believe the patient is a good candidate for an Oral Appliance. I have referred to **Drs. Jason Hui and Alan McDavid**, local dentists who have specialized training in the treatment of patients with OSA with the use of oral appliance therapies. The device that I have prescribed is for the treatment of the patient's OSA, a medical condition, and NOT for any dental disorder.

As you are well aware, OSA with an AHI of 10 or higher merits therapy due to the cardiovascular consequences alone. Failure to treat would be gross negligence. I strongly urge you to cover the costs of this therapy. Failure to do so would place this patient's health in jeopardy.

Sincerely,

(Physicians Name)

Signature: _____