ALLISON & ASSOCIATES

Date:_____/_____/_____

If the patient is diagnosed with obstructive sleep apnea or snoring and is then prescribed oral appliance therapy, please return this form.

FAX TO: (910)295-3913

Referring Provider: Dr. Rebecca Fronheiser
Clinic Name: Allison and Associates
Phone: 910-295-4343
Address: 15 Aviemore Dr.
Pinehurst, NC 28374

PRESCRIPTION FORM / LETTER OF MEDICAL NECESSITY (LOMN) FOR ORAL APPLIANCE THERAPY

CODE – E0486 QUANTITY-1

Patient Name:	**DOB: _____/_____/_____ Age: _____**
Patient Phone #:	**Patient Address:**
Insurance Company: **Group No:** **Account/ID No:**	

Prescribing Physician:

NPI:

Primary Diagnosis: ◯ G47.33 (Obstructive Sleep Apnea) ◯ R06.83 (Snoring)

Secondary Diagnosis:

If required by insurance, this patient is intolerant of CPAP or not a candidate for CPAP therapy? ❑ Yes ❑ No

Duration of Treatment:

Description of Oral Appliance: *ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS*

Additional Physician Remarks:

Treatment Orders (Please Check)
_____Mandibular Advancement Device for treatment of OSA
_____Mandibular Advancement Device to be used in combination with CPAP
_____Mandibular Advancement Device for treatment of primary snoring
_____Other _____

Medical Justification (Patient has tried CPAP and has not tolerated and/or complied with treatment for the following reasons):
_____Unable to tolerate mask/straps _____N/A
_____Unable to tolerate effective Pressure
_____Skin sensitivity _____Claustrophobia
_____Other Continuation of Care

Physician Signature: _____ **Date: _____**

Statement of medical necessity: The above patient has a sleep-disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an ORAL APPLIANCE is medically necessary. Currently, Medicare has a code (E0486) with the following descriptor, "ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS" Treatment duration will be at least one year and could be required for the remainder of the patient's life. If you should have any questions, please contact the prescribing physician.