Letter of Medical Necessity (LOMN) & 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) 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 recommend the patient's health insurance company covers this therapy.

Physician's Name: _____

Office Address: _____

Phone Number: _____

Fax Number: _____

Date: _____

You May Fill This Prescription at:

Houston Sleep Apnea
HSApnea.com
281-612-3153

Michael J. Landry, DDS, ABAD
9700 Louetta Road, Houston, TX 77379