Stationery Proof

☒ New Job ❑ Exact Reprint

❑ Reprint with Changes: ______

Item: **Referral Note Pad** Quantity: **TBD** Paper: **Uncoated** Printing Process: **Full Color**

- 5.5"w x 8.5"h
- 50 sheets per pad

Designer **TJ**

LOMN/RX & Statement of Medical Necessity

Referring Physician: ______________________ Tel: ______________

Patient Name: ______________________ DOB: ______________

Patient Address: ______________________________________

Patient Tel: ______________ Email: ______________________

**Please fax a copy of patient's medical insurance card with this prescription.*

Prescription to be filled by theREALsleep Appliances:

Dr. Elizabeth Rosenthal
305 S. Hamilton Road | Gahanna, OH 43230
tel 614-222-6816 | *fax* 614-871-0500
info@theREALsleep.com • theREALsleep.com

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 ❑ Is not a candidate for C-PAP Therapy

I am prescribing a Mandibular Advance Device (EO486) 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.

Signature of Referring Physician: ______________________

Dr. NPI # ______________ Date: ______________

As a physician, I deem this therapy to be medically necessary.

Please fill out this prescription in its entirety.

*Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.