theREALsleep

Real results, Real solutions, REALsleep

info@therealsleep.com

LOMN/RX and Statement of Medical Necessity

Referring Physician: ________________________________ Tel/Fax: ______________________

Patient Name: __________________________________ DOB:___________________________

Patient Address: ____

Patient Telephone: _____________________ Email:_____________________________________

Please fax copy of patient's medical insurance card and sleep study with this prescription*

Prescription to be filled by SweetDreams Appliances

Dr. Elizabeth Rosenthal
305 S. Hamilton Rd.
Gahanna, Ohio 43230
PH: 614-222-6816
FAX: 614-871-0500

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: ____

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 moreserver with time and requires periodic re-evaluation by a qualified physician.