DenverSleep
APNEA CENTER

PATIENT NAME: _____

Date of Birth: _____

Patient Phone: _____

Insurance ID#: _____

Requesting Dentist's Name: **Dr. Steven Wilk**

Please send Baseline Sleep Study, Demographics,Insurance Card and office visit note.

LETTER OF MEDICAL NECESSITY

The above patient has been diagnosed with Obstructive Sleep Apnea (G47.33). I am prescribing treatment of the diagnosis with a Mandibular Advancement Device E0486).

The prescribed Mandibular Advancement Device is FDA cleared.
I certify that the recommended treatment is medically necessary.
The duration of treatment for this disease is for the lifetime of the patient.
The quantity required is 1 and to follow the standard repair and replacement policies outlined by the patient's insurance plan.

Physician Signature: _____ Date: _____

NPI: _____