Dr. Jesse Whitely, DDS

3113 Professional Drive Suite 1 Auburn, CA 95603
Phone: 530-885-6559 | Fax: 530-885-4142
Email: dr.whitely@foothillsleepsolutions.com
Website: https://foothillsleepsolutions.com

Date:______________

Patient Name : ____

Patient DOB : ____

Patient Phone : ____

Patient E-Mail : ____

Referring Doctor : ____

Referring Dr's Phone/Fax : ____

Medical Insurance Provider : ____________________Medical Insurance ID : ________________

Patient is being referred for an evaluation for Oral Appliance Therapy

HST/ PSG Date:____

Diagnosis:□OSA □Mild □Moderate □Severe Patient currently uses a CPAP : □ Yes □ No Patient declined CPAP and contraindication is noted or is CPAP intolerant : □ Yes □ No Comments :

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LETTER OF MEDICAL NECESSITY (LOMN) AND Rx

Order Date : ____

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 urge you to cover the costs of this therapy. Failure to do so would place the patient's health in jeopardy.

Prescribing Physician (PRINT) : ____________________ NPI : ______________________

Prescribing Physician's Signature : _________________ Date : ______________________

Physician Address : ____

Phone : ______________________________ FAX : _____________________________