MAIN LINE SNORING Solutions

Smile Beautifully. Sleep Comfortably. Live a Healthy Life.

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea & Verification of Medical Necessity Form

In order to facilitate prompt insurance reimbursement for our mutual patient, I ask that you please sign and return this form to the office address listed at the bottom of this document. Once the sleep apnea appliance is in place a follow-up study will be administered to validate the efficacy of treatment. Results will be forwarded to you

Treating Physician Information

Physician Name: _____ Phone#: _____

Office Address: _____

Patient Information

Patient Name: _____ Phone #: _____

Patient Address: _____

Prescription Information

Prescription to be Filled By: Andrew L. Lieberman, D.M.D, LLC – Main line Snoring Solutions

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, with severity of.... ☐ Mild ☐ Moderate ☐ Severe

This Patient is.... ☐ Intolerant of CPAP Therapy ☐ Is not a candidate for CPAP Therapy

Explanation (if necessary): _____

This patient is being sent for Sleep Apnea Therapy utilizing an FDA- Approved Oral Sleep Apnea Appliance.

Medical Necessity Verification & Prescription Authorization

As the patient's treating physician, I deem this therapy to be Medically Necessary.

Physician's NPI#: _____ Physician's License #: _____

Physician's Signature: _____ Date: _____

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