UNC DEPARTMENT OF NEUROLOGY

Print Form

Letter of Medical Necessity for treatment of obstructive sleep apnea

Patient Name _____

Insurance Provider _____

Member ID# _____

To whom it may concern:

My patient was treated in this office for obstructive sleep apnea utilizing a Tap oral appliance. The following is the pertinent information related to his treatment and treatment outcomes.

Diagnosis:

Polysomnogram:

Date _____

RDI _____

Lowest desaturation: _____

Time below 90% saturation: _____

Diagnosis: _____

Remmers sleep recorder

Date _____

RDI _____

Lowest desaturation: _____

Time below 90% saturation: _____

Diagnosis: _____

Results of therapy:

CPAP _____

Surgery _____

TAP oral appliance _____

Remmers sleep recorder

Date _____

RDI _____

Lowest desaturation: _____

Time below 90% saturation: _____

Diagnosis: _____

Sleep apnea quality of life index:

Before _____

After _____

Effect of Treatment [ ]

(after-before)

Epworth Sleepiness Scale:

Before _____

After _____

According to the patients outcomes he is well treated with the TAP appliance and needs to wear the appliance for a lifetime

Doctors' Name _____

Address _____

City _____ State ____ Zip Code _____

Country _____

Doctor's Signature _____