**BILL WOLFE, D.D.S., PA**

**3915 BRISTOL HWY, SUITE 103**

**JOHNSON CITY, TN. 37601**

**(423)461-0073**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**RE: Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The above patient was seen by me recently for a consultation regarding an oral appliance to manage their snoring and sleep apnea. As you know, a sleep study has been performed and resulted I a diagnosis of obstructive sleep apnea.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_has tried the nasal CPAP and is intolerant to it. A reasonable option I light of his/her intolerance is an oral airway dilator appliance (mandibular advancement type), which based on my evaluation may be beneficial.

Currently, in order to proceed with an appliance and potentially receive insurance coverage for it, a recommendation/referral from you is the appropriate action. Please review the statement of medical necessity below, sign it on the line provided and return it to my office at your earliest convenience so that I may proceed with the treatment I a timely fashion.

Thank you for your assistance in this matter. If you wish to speak to me regarding this matter, please feel free to contact me.

Sincerely,

Bill Wolfe, D.D.S., PA

**STATEMENT OF MEDICAL NECESSITY**

An oral airway appliance has been recommended, as stated above, following a sleep study, which confirms a diagnosis of obstructive sleep apnea. I concur that the recommended therapy at this time will be beneficial and is deemed medically necessary.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_