

Letter of Medical Necessity
TAP[®] (Oral Appliance Therapy)

Patient Name _____

Date _____

Physician _____

Diagnosis _____

My patient _____ has been diagnosed with Obstructive Sleep Apnea (OSA) and has an AHI/RDI of _____ events per hour. She/he is not able to tolerate Continuous Positive Airway Pressure (CPAP) therapy due to the intrusive nature of the mask and forced air. The cause of the OSA is due to the fact that _____ his / _____ her jaw falls open and the tissues of the throat and pharynx collapse and block the airway during sleep. The provision of an adjustable mandibular device will stabilize and open _____ his / _____ her airway and will allow for effective treatment of the patient's OSA

Left untreated, my patient may suffer the deadly consequences of any one of the following comorbidities associated with untreated Obstructive Sleep Apnea Syndrome:

- Drug resistant hypertension
- Stroke
- Congestive heart failure
- Diabetes
- Renal failure

In addition, my patient is at increased risk for accidents due to excessive daytime sleepiness.

I am prescribing the TAP[®] device to provide effective treatment for my patient. It requires fabrication by a trained Sleep Dentist and is the only oral appliance for the treatment of OSA that has been proven by over 20 independent clinical trials not associated with the manufacturer of the device.

Dentist Name _____

Address _____

Telephone _____ Email _____

Doctor's Signature _____ Date: _____

License # _____