GAP LETTER WAIVER **Date: _____**

Patient: _____

DOB: _____

ID Number: _____

Dear Prior Authorization / Medical Review Department:

We are requesting authorization for procedure code **E0486**, oral appliance therapy (OAT) for our patient, who has been diagnosed with obstructive sleep apnea (Dx: 327.23). This patient is unable to tolerate CPAP and would like to try oral appliance therapy as a line of treatment.

Included in this fax you will find:

- The patient's CPAP Intolerance Affidavit
- The patient's diagnosing sleep study
- Additional notes to support the request

Though E0486 is considered DME, the proper measurement, fitting and construction of this device must be made by a dentist trained in Dental Sleep Medicine and sent to an outside FDA accredited facility for fabrication. This is why E0486 is billed through our office.

Our office information is:

Oral Sleep Medicine of Arizona
1400 N Gilbert Rd
Gilbert, AZ 85297
480-503-0967
osmedofAZ@gmail.com

DUE TO THE LACK of IN-NETWORK Dental Sleep Medicine providers in our area, we are requesting that benefits for this patient be paid at the highest level and that out-of-network deductibles and coinsurances not apply. If you have any questions, please let me know. Please contact me with your response via the information listed above.

Sincerely,

Johnna Barletta, Marketing/ Operations Director