SleepPhones®

Letter of Medical Necessity

This letter serves as a prescription and letter of medical necessity for the patient referenced below currently being treated.

To be filled out by patient:

Patient Name: _____ Gender: _____ DOB: _____

Address: _____ Phone: _____

City/State/Zip: _____

Physician: _____ Phone: _____

To be filled out by physician regarding patient listed above:

Recommended Treatment: *Use SleepPhones® headphones every night**

Diagnoses (check all that apply):

____ Insomnia (F51.09)

____ Jet Lag Type (G47.2)

____ Environmental Sleep Disorder (F51.8)
Snoring, noisy environment

____ Tinnitus (H93.19)

____ Restless Leg Syndrome (G25.81)

____ Shift Work (G47.26)

____ Misophonia (H93.299)
Other abnormal auditory perceptions, unspecified ear diagnosis

____ Other (Explain): _____

_____

_____

Physician Signature: _____ Date: _____

THANK YOU!

Patient should keep this letter as necessary proof for reimbursement under a Flexible Spending Account, Health Reimbursement Account, or Health Insurance Coverage Plan.

* IMPORTANT DISCLAIMER: While SleepPhones® headphones may promote sleep health in your patients, AcousticSheep LLC does not claim to prevent, diagnose, cure, or treat any diseases or disorders.