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 (F47.25)

_____ Environmental Sleep Disorder (F51.8) (snoring, noisy environment)

_____ Other (Explain): _____

_____ Tinnitus (H93.19)

_____ Restless Leg Syndrome (G25.81)

_____ Shift Work (G47.26)

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.

SleepPhones® are an FDA Listed device but have not been evaluated for effectiveness in double-blind placebo-controlled clinical trials yet.