SomnoGuard®
Oral Appliance
Prescription Form

Certificate of Medical Necessity

Patient (Last, First, MI)_____

Shipping Address:_____

City:_____ St:_____ Zip:_____

E-mail:_____
(Required for NightOwl HST)

Today's Date:_____
Date of Birth (m/d/yy) _____
Home Phone _____ ( )
Cell Phone _____ ( )
Work Phone _____ ( )

* Indicate preferred method to contact

SomnoGuard® Oral Appliance

☑ Please Specify

☐ SomnoGuard® SPX

Ultra Low Profile, Two piece Mandibular Advancement Device
Enhanced Retention Copolymer.
Precision Titration Turnbuckles (0–10mm advancement).
Indicated for Snoring and Mild/Moderate OSA. FDA# K121761

☐ SomnoGuard® AP2

Low Profile, Two Part, Two piece Mandibular Advancement Device
Micro-adjustment Titration, free lateral movement, mouth breathing, Custom Fitted Oral Appliance.
For Snoring and Mild/Moderate OSA. FDA# K061688

Please also authorize patient to purchase:

☐ NightOwl® HST Device. (* eMail required)

4 Channel diagnostic device (PAT, HR, SaO2, Actigraphy), Bluetooth and internet access smartphone required. eMail initiated studies, multi-night capable. Single patient use, REUSABLE for up to 100 hours. FDA# K191031. Number of nights:(1-5)____ ☐ Follow up study

Prescribing Physician Information

Name/Title_____

Address:_____

City:_____ ST:_____

Zip:_____ Phone: _____

Fax:_____

NPI:_____ Rx Code: _____

Primary Diagnostic ICD-10 Code (check) Insurance submission code: E0485

☐ G47.33 Obstructive Sleep Apnea (Adult & Pediatric)	☐ G47.30 Unspecified Obstructive Sleep Apnea	☐ R06 Snoring

_____ _____
Physician Signature Date

Patient attestation for purchase of prescription device

☑ By signing below, I acknowledge that I have consulted the prescribing physician and am purchasing this prescription device for my own use and therapy. The device will be fitted according to the instructions for use and if self-administered, is acknowledged to be done so at my sole risk and responsibility. I acknowledge that I have been advised of the risks associated with the fitting process and use of Oral Appliances and have been recommended to obtain and maintain good dental hygiene and scheduled dental exam visits. I understand the SomnoGuard is provided with a one (1) year warranty against defects in materials and workmanship and that any deviation from the Instructions For Use will void the manufacturer's warranty.

_____ _____
Patient Signature Date

Submit via Fax#: *800-918-7860* Customer Service: 866-720-8080

Secure online order processing also available at:
www.1stlinemedical.com