Certificate of Medical Necessity

SomnoGuard®
Oral Appliance
Prescription Form

Patient (Last, First, MI)_______________________________ Today's Date:________________________

Shipping Address:___________________________________ Date of Birth (m/d/yy) _______________

City:____________________ St:_______ Home Phone ________________________ (
Zip:____________)Cell Phone __________________________ ( )
Work Phone ________________________ ( )

Insurer:_________________ ID#:_____________________

SomnoGuard® Oral Appliance ☑ Please Specify	Prescribing Physician Information
☐ SomnoGuard® SP Soft Two Part, Two piece Mandibular Advancement Device 1mm-Incremental Advancement Positioners included. FDA# K121761. For Snoring and Mild/Moderate OSA. ☐ SomnoGuard® AP2 Two Part, Two piece Mandibular Advancement Device Micro-adjustment Titration, free lateral movement, mouth breathing, Custom Fitted Oral Appliance. FDA# K061688. For Snoring and Mild/Moderate OSA.	Name/Title____ Address:____ City:______________________________ ST:_____________ Zip:________________ Phone: ________________________ Fax:___________________________ NPI:________________________________

Primary Diagnostic ICD-9 Code (check) Insurance submission code: HCPCS E0485/CPT 21085

☐ G47.33 Obstructive Sleep Apnea (Adult & Pediatric)	☐ G47.00 Unspecified Obstructive Sleep Apnea	☐ G46.09 Snoring

Indication ☑

☐	Snoring
☐	Mild OSA: AHI/RDI: ___ Documented by PSG/HST: _______ OSA Complications: ☐EDS ☐Hypertension ☐Epworth Score_____ ☐Cognitive Dysfunction (attach Sleep Study Results and interpretation)
☐	Moderate OSA: AHI/RDI: ___ Documented by PSG/HST: _______ OSA Complications: ☐EDS ☐Hypertension ☐Epworth Score_____ ☐Cognitive Dysfunction (attach Sleep Study Results and interpretation)
☐	Severe OSA: AHI/RDI: ___ Documented by PSG/HST: _______ CPAP Intolerance: ____ days OSA Complications: ☐EDS ☐Hypertension ☐Epworth Score_____ ☐Cognitive Dysfunction (attach Sleep Study Results and interpretation)
☐	Severe OSA: AHI/RDI: ___ Documented by PSG/HST: _______ Lower PAP pressure: ___cm Complications: ☐EDS ☐Hypertension ☐Epworth Score_____ ☐Cognitive Dysfunction (attach Sleep Study Results and interpretation)
☐	Mild/Moderate/Severe OSA, Secondary Therapy: ☐ Travel ☐ Restrictions to consistent CPAP use:_________________________________

______________________________ ______________________________ __________
Physician Name Physician Signature Date