



### Certificate of Medical Necessity

Patient (Last, First, MI) \_\_\_\_\_  
Shipping Address: \_\_\_\_\_  
City: \_\_\_\_\_ St: \_\_\_\_\_  
Zip: \_\_\_\_\_  
E-mail: \_\_\_\_\_

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

\* Indicate preferred method to contact

<b>SomnoGuard® Oral Appliance</b> <input checked="" type="checkbox"/> Please Specify	<b>Prescribing Physician Information</b>
<input type="checkbox"/> <b>SomnoGuard® SPX</b> 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  <input type="checkbox"/> <b>SomnoGuard® AP2</b> 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	Name/Title _____ Address: _____ City: _____ ST: _____ Zip: _____ Phone: _____ Fax: _____ NPI: _____ Rx Code: <input type="text"/>

Primary Diagnostic ICD-10 Code (check)

Insurance submission code: E0485

<input type="checkbox"/> G47.33 Obstructive Sleep Apnea (Adult & Pediatric)	<input type="checkbox"/> G47.30 Unspecified Obstructive Sleep Apnea	<input type="checkbox"/> R06 Snoring
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\_\_\_\_\_  
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](http://www.1stlinemedical.com)