1ST LINE Medical Inc.

Tomed® MAD
Physician Patient
Prescription / Order Form

Certificate of Medical Necessity

Patient (Last, First, MI) _____ **Today's Date** _____

Patient Address _____ **Date of Birth (m/d/yy)** _____

City: _____ St:_____ Zip:_____ **Home Phone** _____ ( )*

Cell Phone _____ ( )*

e-mail _____ **Work Phone** _____ ( )*

(*indicated preferred method to contact)

TOMED® ORAL APPLIANCE

(☑ please specify)

☐ **SOMNOGUARD**
Mandibular Advancement Device
non-adjustable
for Snoring and Mild/Moderate OSA

☑ **SOMNOGUARD AP**
Mandibular Advancement Device
Adjustable/Titratable
for Snoring and Mild/Moderate OSA

PRESCRIBING PHYSICIAN INFORMATION

Name/Title: _____

Address: _____

City:_____ ST:_____

Zip:_____ Phone: _____

Fax: _____

NPI:_____ License#:_____

Primary Diagnostic ICD-9 Code (check)

☐ **327.23 Obstructive Sleep Apnea (Adult & Pediatric)** ☐ **750.87 Unspecified Obstructive Sleep Apnea** ☐ **786.09 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 by an appropriately trained and credentialed clinician according to the Instructions for use. I intend to use the device according to my physician's recommendations and according to the patients instruction for use. I further understand that any deviation from this protocol will void the manufacturers warranty.

_____ _____
Patient Signature Date

Submit via FAX #: ***800-918-7860***

Phone Number: 866-720-8080