NightOWL® HST
Prescription Form

Certificate of Medical Necessity

Patient (Last, First, MI)_____

Shipping Address:_____

City:_____ St:_____ Zip:_____

E-mail:_____
(Required for NightOwl HST Study initation)

Today's Date:_____
Date of Birth (m/d/yy) _____
Home Phone _____ ( )
Cell Phone _____ ( )
Work Phone _____ ( )
* Indicate preferred method to contact

NightOwl® Sleep Test Device ☑ Please Specify	Prescribing Physician Information
☐ 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)____ Indication: ☐ Initial Diagnosis: High likelihood of OSA ☐ Follow up study (☐ Already has NightOWL) ☐ Titration of Oral Appliance ☐ Confirmation of Oral Appliance efficacy ☐ Confirmation of PAP Efficacy ☐ Follow up study - Surgery ☐ Follow up study – Weight Loss/Gain ☐ Follow up study – Positional Therapy ☐ Follow up study – Other:_____	Name/Title_____ Address:_____ City:_____ ST:_____ Zip:_____ Phone: _____ Fax:_____ NPI:_____

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

NIGHTOWL

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. The device will be used according to the instructions for use and self-administered, for which I accept responsibility for downloading the NightOWL App and connecting via Bluetooth and Wifi to transmit the data, which is securely handled as private healthcare information. Results from the assessments performed with the NightOWL are only available from the Prescribing Physician. I understand the NightOWL is provided with a one (1) year warranty against defects in materials and workmanship and 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