



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 <input checked="" type="checkbox"/> Please Specify	Prescribing Physician Information
<input type="checkbox"/> SomnoGuard® AP2 Low Profile, Two part, Two piece Mandibular Advancement Device, 0- 10mm. 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: _____
<input type="checkbox"/> SomnoGuard® SPX Two Part, Two piece Mandibular Advancement Device 1mm-Incremental Advancement Positioners included. FDA# K121761. For Snoring and Mild/Moderate OSA.	

Primary Diagnostic ICD-10 Code (check)

Insurance submission code: HCPCS E0485/CPT 21085

<input type="checkbox"/> 47.33 Obstructive Sleep Apnea (Adult & Pediatric)	<input type="checkbox"/> 47.30 Unspecified Obstructive Sleep Apnea	<input type="checkbox"/> R06 Snoring
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Indication

(Contraindications: Dentures, Peridontal Disease, Complex occlusion, inadequate teeth (8 U&L), immobile mandible)

<input type="checkbox"/>	Snoring
<input type="checkbox"/>	Mild OSA: AHI/RDI: ____ Documented by PSG/HST: _____ Date of Study: _____ OSA Complications: <input type="checkbox"/> EDS <input type="checkbox"/> Hypertension <input type="checkbox"/> Epworth Score ____ <input type="checkbox"/> Cognitive Dysfunction (attach Sleep Study Results and interpretation)
<input type="checkbox"/>	Moderate OSA: AHI/RDI: ____ Documented by PSG/HST: _____ Date of study: _____ OSA Complications: <input type="checkbox"/> EDS <input type="checkbox"/> Hypertension <input type="checkbox"/> Epworth Score ____ <input type="checkbox"/> Cognitive Dysfunction (attach Sleep Study Results and interpretation)
<input type="checkbox"/>	Severe OSA: AHI/RDI: ____ Documented by PSG/HST: _____ CPAP Intolerance: ____ days OSA Complications: <input type="checkbox"/> EDS <input type="checkbox"/> Hypertension <input type="checkbox"/> Epworth Score ____ <input type="checkbox"/> Cognitive Dysfunction (attach Sleep Study Results and interpretation)
<input type="checkbox"/>	Severe OSA: AHI/RDI: ____ Documented by PSG/HST: _____ Lower PAP pressure: ____ cm Complications: <input type="checkbox"/> EDS <input type="checkbox"/> Hypertension <input type="checkbox"/> Epworth Score ____ <input type="checkbox"/> Cognitive Dysfunction (attach Sleep Study Results and interpretation)
<input type="checkbox"/>	Mild/Moderate/Severe OSA, Secondary Therapy: <input type="checkbox"/> Travel <input type="checkbox"/> Restrictions to consistent CPAP use: _____

Physician Name

Physician Signature

Date