SomnoGuard®
Oral Appliance
Prescription Form

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 _____ ( )

* Indicate preferred method to contact

SomnoGuard® Oral Appliance ☑ Please Specify	Prescribing Physician Information
☐ SomnoGuard® AP2 Low Profile, Two Part, Two piece Mandibular Advancement Device Micro-adjustment Titration, free lateral movement, mouth breathing, Custom Fitted Oral Appliance. Indicated for Snoring and Mild/Moderate OSA. FDA# K061688 ☐ SomnoGuard® AP2 Fitting Kit Only Comprehensive Home Fitting Kit to enable self-administration of the AP2 procured from the practice: Heating Kettle/Strainer, Timer, Scissors, Mirror, Gloves, Fitting Guide, Online fitting video reference, 2 way video-conference available.	Name/Title_____ Address:_____ City:_____ ST:_____ Zip:_____ Phone: _____ Fax:_____ NPI:_____ Rx Code:

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

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.

eMail form to: Service@1stLineMedical.com
or

_____ _____
Patient Signature Date

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

Customer Service: 866-720-8080

www.1stlinemedical.com