



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** _____ ()
** permission to text? Y N

Table with 2 columns: SomnoGuard AP2 product details and Prescribing Physician Information.

Primary Diagnostic ICD-10 Code (check)

Insurance HCPCS code: E0485

Grid of checkboxes for ICD-10 codes: G47.33 Obstructive Sleep Apnea, G47.30 Unspecified Obstructive Sleep Apnea, R06 Snoring.

Step 1: Complete & Sign Form. Fax to 800-918-7860. Includes Physician Signature and Date lines.

Step 2: Provide patient Sleep Well Brochure & FAQ and/or share QR Code



Help4OSA.com

Prescription device requirements and disclaimer

By exercising this prescription, 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.

Step 3: 1st Line contacts to facilitate purchase, USPS delivery and steps to initiate therapy

Customer Service: 866-720-8080