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 ___________________________ ( )
Work Phone __________________________ ( )
* Indicate preferred method to contact

SomnoGuard® Oral Appliance ☑ Please Specify Model	Prescribing Physician Information
☐ **SomnoGuard® AP2** Two-part, two-piece Mandibular Advancement Device Micro-adjustment Titration, free lateral movement, mouth breathing, Prefabricated Custom Fitted Oral Appliance. FDA cleared for Snoring and OSA. FDA# K061688 ☐ **SomnoGuard® SPX** Low profile, Two-part, two-piece Mandibular Advancement Device. Incremental Advancement positioners (0–10mm advancement in 1mm increments) included. Lateral dimension customizable. FDA cleared for Snoring and Mild/Moderate OSA. FDA# K121761	Name/Title____ Address:____ City:______________________________ ST:____________ Zip:________________ Phone: _________________________ Fax:__________________________ NPI:_____________________ Rx Code: [ ]

Primary Diagnostic ICD-10 Code (check) Insurance HCPCS code: E0485

☐ G47.33 Obstructive Sleep Apnea (Adult & Pediatric)	☐ G47.30 Unspecified Obstructive Sleep Apnea	☐ R06 Snoring

AP2 SPX
Scan to purchase

_______________________________ ___________
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.

_______________________________ ___________
Patient Signature Date

Submit via Fax#: 800-918-7860

Customer Service: 866-720-8080

Secure online order processing also available at: www.1stlinemedical.com