eXciteOSA | Prescription Form

Patient Name: _____ DOB: _____

Street Address: _____

City/Town: _____State: _____ Zip Code: _____

Phone: _____ Email: _____

Insurance Provider: _____ Policy Number (if available): _____

Diagnosis:

☐ Mild obstructive sleep apnea - ICD-10 G47.33

☐ Primary snoring - ICD-10 R06.83

Rx:

☐ eXcite[OSA®] Starter Kit – Includes control unit (HCPCS K1028) and mouthpiece (HCPCS K1029)
Therapy frequency of 20 minutes per day x 6 weeks, and then 20 minutes x 2 days per week maintenance

☐ Mouthpiece refill every 90 days - HCPCS K1029

☐ Duration of use – Lifetime need

Physician Office Street Address: _____

Phone: _____ **NPI/UPIN:** _____

Physician Office Email Address: _____

Physician Signature: _____ **Date:** _____

Physician Name: _____

Notes: _____

_____

Dispense as Written – No Substitutions

MAXCARE HEALTH

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