## Letter of Medical Necessity / Prescription iNAP Sleep Therapy System – Treatment for Obstructive Sleep Apnea

Patient In							
Patient Na	ime						
Patient DC	)B						
Gender		□ Male □Female					
Physician	Information						
Physician Name							
Physician NPI Number							
Physician Phone Number							
Physician	Address						
I am writing on behalf of my patient, to document the medical necessity of iNAP®, a nonsurgical device indicated for home use in the treatment of obstructive sleep apnea (OSA). This letter provides information about the patient's medical history, clinical diagnosis and a statement certifying the necessity of this medical treatment.  Patient's History and Diagnosis							
iNAP®, In		oard-Certified Sleep Physician with Obstructive Sleep Apnea (OSA) (G47.33) who has recommended ve Airway Pressure Sleep Therapy (HCPCS E0600).					
This patie	nt ie:						
		, has rejected CPAP, or after trialing CPAP, is noncompliant(E0601)					
	Has tried and ca	annot use an Oral Appliance (E0486)					
	Has been impac sleep apnea.	sted by the Philips CPAP recall and/or supply chain issues and has been unable to treat their obstructive					
Other:							
Diagnosis							
	Obstructive Slee	ep Apnea (G47.33)					
	Unspecified Sle	ep Apnea (G47.30)					
	Snoring (R06.83						
	Nocturnal Bruxi	sm (G47.63)					
	Hypersomnia U	nspecified (G47.10)					
-							

**Product Description** 

iNAP is a prescription device manufactured by Somnics Health with the following indications for use: iNAP is a removable intraoral

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pressure gradient device, electrically powered and operates by reducing the pressure in the oral cavity (by way of tubing and a noninvasive oral interface) to create a continuous positive pressure gradient from the airway to the oral cavity that urges the soft palate and tongue forward. It is intended to be used while a patient is sleeping to treat obstructive sleep apnea. FDA Classification Device Class 2, FDA clearance 510 (k) submission K193460 (05/26/2020).

## **Prescription**

The following device and accessories are medically necessary

Check if applicable	HCPCS Code	Description	Dispense QTY	Refill QTY	DME or DME Accessory
	E0600	iNAP console	1		DME
	A7001	Saliva container	1	1 Every 6 months	Accessory
	A7002	Tubing	1	1 Every 3 months	Accessory
	A7047	Oral interface	1	1 Every 3 months	Accessory
	A9900	Dry pads	92	1 Every day	Accessory

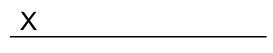
The above-referenced patient was diagnosed as indicated.

This document serves as a Prescription and Statement of Medical Necessity to treat their obstructive sleep apnea (OSA) to prevent the cardiac, neurological, and psychiatric consequences on untreated OSA.

I certify that I am the physician identified in the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge.

I certify that iNAP is indicated as a treatment and in my opinion, is reasonable and medically necessary regarding the standards of medical practice for this patient's condition.

In the absence of any diagnosed medical condition such as Central Sleep Apnea or congestive heart failure, or any other medical condition known to be contraindicated, I am prescribing the iNAP Sleep therapy system.



MD / DO / NP / PA-C

