



# FAX- Confidential

To: Max Care Health

From: \_\_\_\_\_

Phone: \_\_\_\_\_

Re: iNAP Sleep Therapy Request

Fax # 516-706-4476

Pages-

Certificate of Medical Necessity /Prescription for the iNAP Sleep Therapy System

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Phone 516-628-7149 zeb@maxcarehc.com  
Fax 516-706-4476 www.maxcarehc.com



Please fax this form to:  
516.706.4476

## Prescription and Certificate of Medical Necessity

This document serves as a Prescription and Statement of Medical Necessity for the patient referenced below for the Somnics iNAP Sleep Therapy System and any items indicated.

### Patient Information

Patient First Name, Last Name	Gender	DOB
Primary Phone	Alternate Phone	
Street Address	City/State/Zip	
Email Address		

### Diagnosis

G47.33 Obstructive Sleep Apnea   
  Hypertension   
  Hypersomnolence   
  Ischemic Heart Disease   
  Insomnia  
 Depression                     
  Stroke           
  Other:

### iNAP Sleep Therapy System

iNAP Starter Kit (container, oral Interface, tubing, 93 Day's Supply of Dry Pads)  
 Replenishment:  Oral Interface   
  Tubing   
  DryPad (3 months' supply)   
  Other.....  
 Length of need= lifetime- 99

### Physician Information

Name	NPI#	
Address	City:	State    Zip
Phone #	Fax #	
Signature	Date	
	Email (non PHI only):	

*When referred by qualified referral sources, all patients will be admitted by Somnics Health for continuing services. Should services be requested that Somnics does not provide, we will direct patients to the appropriate resource. Prices for all products and services are available upon request. Somnics provides sleep therapy products In California only until further notice.*

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