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**

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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