FAX- Confidential	
To: Somnics Health From: ________________________ Phone:____________________ Re: INAP Sleep Therapy Request	Fax # 833-847-2009 Pages-

- Certificate of Medical Necessity /**Prescription for the INAP Sleep Therapy System**

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Please fax this form to:
1.833.847.2009

Prescription and Letter of Medical Necessity

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

Diagnosis

( ) G47.33 Obstructive Sleep Apnea ( ) 780.57 Other unspecified sleep apnea ( ) Other

iNAP Sleep Therapy System

( ) iNAP Starter Kit (container, oral Interface, tubing, 93 Day's Supply of Dry Pads)
Pressure Range:
( ) 1: 22~43 cmH2O ( ) 2: 44~67 cmH2O ( ) 3: 63~86 cmH2O ( ) 4: 82~105 cmH2O ( ) 5: 101~122 cmH2O

AHI \ BMI	20	24	28	32	36	40
60	4	4	4	5	5	5
50	3	4	4	4	5	5
40	3	3	3	4	4	5
30	3	3	3	3	4	4
20	2	2	2	3	3	4
10	1	2	2	2	3	3

Replenishment: ( ) Oral Interface ( ) Tubing ( ) DryPad (3 months' supply) ( ) Length of need= lifetime- 99

Physician Information

Name		NPI#	
Address	City:	State	Zip
Phone #	Fax #		
Signature	Date		
	Email (Needed for access to Patient Compliance & Pressure Adjustments):		

When referred by qualified referral sources, all patients will be admitted by Somnics Health for continuing services. Should services be requested that Somnic Health does not provide, we will direct patients to the appropriate resource.

QnA for providers: https://shorturl.at/tELP6 or scan this QR code: