eXciteOSA | Prescription Form

Patient Information

Patient Name: _____ DOB: _____

Street Address: _____

City/Town: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Insurance Information

Please attach front and back image of insurance card or fill out the information below.

Insurance Payer Name: _____ Payer ID: _____

Plan Name/Type: _____ Cardholder (Member) Name: _____

Member ID#: _____ Employer: _____

Group #: _____ Provider Phone #: _____

Provider Website URL: _____ Secondary Insurance: ☐ Yes or ☐ No

Primary Diagnosis:

☐ Mild obstructive sleep apnea: ICD-10 G47.33 ☐ Primary snoring: ICD-10 R06.83

Secondary Diagnosis:

☐ Excessive daytime sleepiness ☐ Impaired cognition ☐ Mood disorders ☐ Insomnia
☐ Hypertension ☐ Ischemic heart disease ☐ History of stroke

Rx:

☐ eXciteOSA® 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 a day at a minimum of 2 days per week for maintenance.
☐ Mouthpiece refill, 1 unit every 90 days - HCPCS K1029
☐ Duration of use – 99 months (99=Lifetime)

Physician Office Street Address: _____

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

Physician Office Email Address: _____

Physician Signature: _____ **Date:** _____

Physician Name: _____

Notes: _____

Patient Consent

☐ By checking this box, the patient provides consent for their physician to share this information with Signifier Medical Technologies and their business partners.

Dispense as Written – No Substitutions

Unless instructed to have filled at your local home medical equipment provider, please send fax to Signifier Medical at **413-225-8789** or email to **fax@signifiermedical.com**.

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