eXciteOSA

Authorization Request Reference # (Optional): _____

Patient Information

Patient Name: _____

Patient DOB: _____ Member ID: _____

Physician Information

Physician Name: _____

Physician Phone: _____ Physician Fax: _____

I am writing on behalf of my patient, _____ to document the medical necessity of eXciteOSA®, a tongue neuromuscular electrical stimulation (NMES) device for 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 (Include information regarding the patient's condition, medical history, and specific diagnosis):

_____

_____

Clinical Findings from Sleep Study (Sleep Study Date): _____

AHI: _____ RDI: _____ ODI: _____

Other key results: _____

Diagnosis: Obstructive Sleep Apnea (OSA) (ICD-10 G47.33)

Other chronic conditions or co-morbidities: _____

Therapies refused, contraindicated, or not tolerated by patient: _____

Treatment Rationale: (Include information on the treatment up to this point, course of care and why the treatment/medication/ equipment (item in question) is necessary, and how you expect that it will help the patient.): _____

_____

Product Description: eXciteOSA is a Health Canada approved (LN/HN: *99563 Device ID*: 1027134 08/23/2017) and FDA authorized (DEN200018 2/5/2021) tongue neuromuscular electrical stimulation (NMES) device for mild obstructive sleep apnea (OSA) manufactured by Signifier Medical Technologies.

The following device and accessories are medically necessary:

	Product Description	Dispense QTY	Refill QTY	DME or Accessory to DME
☐	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle for the reduction of snoring and obstructive sleep apnea, controlled by phone application.	1	0	DME
☐	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by smartphone application, 90-day supply.	1	3	Accessory to DME

The above-named patient was diagnosed as indicated. Due to the potentially dangerous consequences of disturbed sleep and sleep deprivation, which include the possibility of falling asleep while operating heavy equipment or while performing life sustaining activities, treatment of this condition is mandatory and not elective.

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for an eXciteOSA Controller NMES device, eXciteOSA Controller NMES mouthpiece replacements, and all associated OSA supplies to be provided by Signifier Medical Technologies or an authorized distributor. 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.

Signature: _____ Date: _____

Signifier MEDICAL TECHNOLOGIES
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