eXciteOSA | Prescription Form

Patient Name: _____ DOB: _____

Street Address: _____

City/Town: _____State:_____ Zip Code:_____

Phone: _____ Email: _____

Diagnosis:

☐ Mild obstructive sleep apnea - ICD-10 G47.33

☐ Primary snoring - ICD-10 R06.83

Rx:

☐ eXciteOSA® therapy - frequency of 20 minutes a day x 6 weeks, and then 20 minutes x 2 days per week maintenance

Mouthpiece Refill:

☐ Every 90 days

Physician Name: _____ **Date:** _____

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

Physician Office Email Address: _____

Physician Signature: _____

Notes: _____

_____

Dispense as Written – No Substitutions

MAXCARE HEALTH

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