Detailed Written Order

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____ Phone #: _____

Insurance Company: _____ Group #/ID#: _____
Insured Name: _____ Insurance Phone #: _____

Secondary Insurance: _____ Group #/ID#: _____
Insured Name: _____ Insurance Phone #: _____

MEDICAL INFORMATION

Diagnosis & ICD-10 CM Code: ☐ N39.3 Stress Urinary Incontinence, female
☐ Other: _____

Has patient undergone and failed a 4 week documented trial of Pelvic Muscle Exercise (PME) training?
☐ Yes ☐ No

Is patient cognitively intact? ☐ YES ☐ NO

Are the pelvic nerves intact? ☐ YES ☐ NO

ELITONE device prescribed to: ☐ Decrease urinary leakage associated with stress urinary incontinence
☐ Other: _____

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PRESCRIPTION

I am prescribing the ELITONE device (HCPCS Code E0740) with GelPads (HCPCS Code A4595)

Quantity: ☐ One ELITONE Device + 2 GelPads ☐ Other _____

Length of Need: ☐ Lifetime (≥ 13 months) ☐ Other _____

Prescribing Physician Name: _____ UPIN #: _____
Facility Address: _____ NPI #: _____
Physician Signature: _____ Phone #: _____
Date: _____ FAX #: _____

Deliver To: ☐ Clinician's Facility ☐ Patient's Home*

I certify that I am the physician identified in this form. I have reviewed all sections of the physician's written order. Any statement on my letterhead attached here to has been reviewed and signed by me. The patient's record contains supporting documentation which substantiates the utilization and medical necessity of the ELITONE device and physician notes will be provided to an authorized distributor upon request. I understand any falsification, omission or concealment of material fact may subject me to civil or criminal liability. *My above signature indicates my approval to ship the instrument to my patient's home and releases shipper from any liability from its use prior to proper instrument education and training.