

Elitone Reimbursement Guide

Elidah, the maker of [ELITONE](#), does not process insurance claims. You will need to provide payment when you place your ELITONE order. This guide is provided to assist individuals who wish to pursue reimbursement of their ELITONE purchase from an insurer. Elidah makes no guarantee that a purchaser will be able to obtain reimbursement for their ELITONE purchase.

Private Insurance

Many private insurers provide coverage for devices like ELITONE. When speaking to your insurance provider to determine reimbursement eligibility, use the description “**non-implantable pelvic floor electrical stimulator**” and the HCPCS/DME Code “**E0740**”. Every insurer has different coverage policies and requirements and may require you to obtain the following:

- A prescription for ELITONE from a treating physician (possibly requiring face-to-face visit)
- A physician’s statement that you tried and failed a 4 week pelvic floor muscle exercise program.
- A Letter of Medical Necessity from a treating physician. See the “Detailed Written Order” (following page) that your physician can use as a template. Download info for your doctor [here](#).

Product Name	Model Number	HCPCS Code	Description	Price
ELITONE Device	EK-1006	E0740-NU	Non-implanted pelvic floor electrical stimulator, complete, Purchased new.	\$399
ELITONE GelPads Pack of 5	EE-1002	A4595	Electrical stimulator supplies	\$28

Healthcare Savings Accounts (HSA) / Flexible Spending Accounts (FSA)

ELITONE is eligible for payment using HSA and FSA accounts (typically through employer or insurance provider). At checkout, enter your HSA/FSA card numbers like you normally would with any credit card. Alternatively, check out using your normal credit card and get reimbursed directly from your HSA/FSA provider.

Medicare

ELITONE has approval for nationwide Medicare coverage and is considered Durable Medical Equipment (DME), which must be obtained from a licensed DME provider. The DME provider will rent an ELITONE device (E0740-RR) to you on a monthly basis (up to 13 months, after which it is owned), and you will be responsible for an out-of-pocket cost of about \$130. Also note that the device you receive may be previously used and you may need to pay out-of-pocket for additional GelPads. If you are interested in this option please have your doctor complete the attached Detailed Written Order and send it to our DME partner at: customerservice@physiotech.com.

Product and Manufacturer Information

ELITONE is manufactured by: Elidah, 810 Main St. Ste C, Monroe, CT 06468
Customer Care contacts: customercare@elitone.com, 978-435-4324, elitone.com

Additional reference codes that your insurer or physician might ask for include:

- NCD Code – 230.8 (Non-implantable pelvic floor electrical stimulator)
- CPT Code - Pelvic Floor Electrical Stimulation with 599.82 Intrinsic (urethral sphincter) with 625.6 Stress Incontinence, female
- ICD-10-CM Code - N39.3 Stress urinary incontinence (SUI)

Detailed Written Order

PATIENT INFORMATION

Patient Name: _____
Address: _____

Date of Birth: _____
Phone #: _____

Insurance Company: _____
Insured Name: _____

Group #/ID#: _____
Insurance Phone #: _____

Secondary Insurance: _____
Insured Name: _____

Group #/ID#: _____
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

Date of most recent in-office visit: _____

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 (\geq 13 months) Other _____
UPIN #: _____

Prescribing Physician Name: _____
Facility Address: _____
Physician Signature: _____
Date: _____

NPI #: _____
Phone #: _____
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.

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