Elitone Detailed Written Order

SCAN for fillable online form

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

_____ Email: _____

Insurance Plan: _____

☐ Original Medicare, Part B Group Group #/ID#: _____

Insured Name: _____ Insurance Phone #: _____

Secondary Insurance: _____ Group #/ID#: _____

Insured Name: _____ Insurance Phone #: _____

MEDICAL NECESSITY

Diagnosis & ICD-10 CM Code:	Medical Device Prescribed:
◯ N39.3 Stress Urinary Incontinence ◉ N39.46 Mixed Incontinence	**Elitone** Pelvic Floor Muscle Stimulator (HCPCS E0740), GelPads (HCPCS A4595) (contracts muscles for toning + some calming signals)
◯ N39.41 Urge Urinary Incontinence	**Elitone URGE** Pelvic Floor Stimulator (HCPCS E0740), GelPads (HCPCS A4595) (calms bladder and surrounding structures)

**Requires additional intervention following a structured 4-week pelvic floor program. ☐ Yes ☐ No

Description: _____

Date of most recent visit: _____ Length Need: ☐ Lifetime (≥ 13 months) or Other _____

DELIVER TO

◉ Patient's Home *(Default)*

◯ *Clinician's Facility: _____

Clinic Address: Care of: _____

_____

*By requesting shipment to a location that is not the patient's home, I confirm that this order is for the specific patient identified on this prescription. I agree that the device will not be held as stock or dispensed to any other individual, and that I assume responsibility for delivery to this patient.

PRESCRIPTION

I am prescribing the above device to decrease urinary leakage associated with urinary incontinence.

Prescribing Physician Name: _____ NPI #: _____ Phone #: _____

Physician Address: _____ Fax #: _____

Physician Signature: _____ Date: _____

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 Elidah or an authorized distributor upon request. I understand any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

ATTACH: 1) Documentation of 4 weeks of pelvic floor muscle exercises were attempted **2) Insurance card.**
Send this form and any attachments to: **FAX: 833-830-1310** or **EMAIL:** billing@elidah.com

Elidah, Inc., the maker of Elitone, may process this prescription and/or pass it on to a DME partner for processing. Elidah may maintain contact information to enable follow-up regarding completion of the order.