elitone

Elitone Detailed Written Order

DME scripts

SCAN for fillable online form

PATIENT INFORMATION (*required)

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 Muscle Stimulator (HCPCS E0740), GelPads (HCPCS A4595) (calms bladder and surrounding structures)

**Requires additional intervention following 4-weeks of pelvic floor muscle exercises. ☐ Yes ☐ No

Description or attach brief chart notes supporting medical necessity after exercises: _____

_____

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

DELIVER TO

◯ Patient's Home *(Default)*

◯ §Clinic/Clinician Name: _____

Clinician Address: (Care of) _____

_____

§By requesting shipment to a non-patient address, I confirm that this order is solely for the patient named on this prescription. I agree the device will not be stocked or dispensed to anyone else, 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 and that I have reviewed all sections of this physician's written order. Any statement on my letterhead attached hereto has been reviewed and signed by me. The patient's record contains supporting documentation which substantiates the medical necessity and utilization 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 a material fact may subject me to civil or criminal liability.

Submit this DWO, Chart note and Insurance Card (if available) by FAX to 833-830-1310 or EMAIL: billing@elidah.com

To avoid delays, please ensure patient contact, insurance, and notes are complete.

Elidah, Inc., may process this prescription and/or forward it to a DME partner for processing, and retain contact information for order follow-up.