



Detailed Written Order



SCAN for fillable online form

PATIENT INFORMATION (*required)

* Patient Name: _____ * Date of Birth: _____
 * Address: _____ * Phone #: _____
 _____ * Email: _____
 Type of Insurance: Original Medicare, Part B Medicare Advantage Medicaid PPO HMO Other
 * Primary Insurance Plan: _____ Secondary Insurance Plan: _____
 * Group # / ID #: _____ * Group # / ID #: _____
 Insurance Phone #: _____ Insurance Phone #: _____
 Insured Name: _____ Insured Name: _____

MEDICAL NECESSITY

* Medical Device Prescribed:

* Diagnosis & ICD-10 CM Code:

<input type="checkbox"/> Elitone for Men Pelvic Floor Stimulator (HCPCS E0740), GelPads (HCPCS A4595). Aids continence recovery in men following prostate surgery.	<input type="checkbox"/> N39.3 Stress Urinary Incontinence <input type="checkbox"/> N39.46 Mixed Incontinence
<input type="checkbox"/> Elitone Pelvic Floor Muscle Stimulator (HCPCS E0740), GelPads (HCPCS A4595). Contracts and calms pelvic floor muscles in female patients.	<input type="checkbox"/> N39.3 Stress Urinary Incontinence <input type="checkbox"/> N39.46 Mixed Incontinence
<input type="checkbox"/> Elitone URGE Pelvic Floor Stimulator (HCPCS E0740), GelPads (HCPCS A4595). Calms overactive bladder in female patients.	<input type="checkbox"/> N39.41 Urge Urinary Incontinence

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

For Elitone and Elitone URGE only. Is additional intervention following 4-weeks of pelvic floor muscle exercises required? Yes No
If yes, provide rationale (or attach brief chart notes) supporting medical necessity after exercises:

DELIVERY

Patient's Home (Default) Clinic / Clinician: _____
 Attention: _____
 Address: _____
 By requesting shipment to a non-patient address, I confirm that this order is solely for this patient. 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 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 specified 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.

* Prescribing Physician Name: _____ * NPI #: _____
 Physician Address: _____ Phone #: _____
 _____ Fax #: _____
 * Physician Signature: _____ Date: _____

Submit this **DWO**, **Insurance Card(s)**, and **Chart Notes** (as applicable) by
FAX: 833-830-1310 or **EMAIL: billing@elidah.com**

To avoid delays, please ensure information is complete.
Elidah, Inc. may process this prescription directly or forward it to a DME partner for fulfillment.