elitone

Detailed Written Order

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:
☐	**Elitone for Men** Pelvic Floor Stimulator (HCPCS E0740), GelPads (HCPCS A4595). Aids continence recovery in **men** following prostate surgery.	☐ N39.3 Stress Urinary Incontinence ☐ N39.46 Mixed Incontinence
☐	**Elitone** Pelvic Floor Muscle Stimulator (HCPCS E0740), GelPads (HCPCS A4595). Contracts and calms pelvic floor muscles in **female** patients.	☐ N39.3 Stress Urinary Incontinence ☐ N39.46 Mixed Incontinence
☐	**Elitone URGE** Pelvic Floor Stimulator (HCPCS E0740), GelPads (HCPCS A4595). Calms overactive bladder in **female** patients.	☐ 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

☐ Pharmacy Pickup *(Default)*

☐ Patient's Home

☐ Clinic / Clinician: _____

Attention: _____

Address: _____

_____

By requesting delivery to someone other than the patient, 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 the biller and/or payer 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) for processing.

Pharmacy: _____

FAX: _____

Email: _____

Phone: _____