

DOCTOR ORDER

Your patient has ordered a Vacuum Erection System from us.

Instructions: Please fill in both Sections and fax back to MedEnvios HealthCare at 1-800-859-4795

Patient Information	Physician Information
Name: _____	Name: _____
Address: _____ _____	Contact: _____
Telephone: (____) _____ - _____	Address: _____
HICN: _____	Telephone: (____) _____ - _____
DOB: ____/____/____	Fax: (____) _____ - _____
	UPIN #: _____

1 → Medicare/Insurance **MEDICAL NECESSITY** regulations require that we have both Primary and Secondary Diagnosis Codes for the External Erection System. Please check (2) appropriate boxes:

PRIMARY
DIAGNOSIS



- 607.84** Impotence of Organic Origin (Erectile Dysfunction)
- Other: ICD _____, ____ Description: _____

SECONDARY
DIAGNOSIS



- 250.01** Type 1 IDDM (Insulin Dependent Diabetes Mellitus)
- 250.00** Type 2 NIDDM (Non-Insulin Dependent Diabetes Mellitus)
- 250.61** Diabetes w/ Neurological Manifestations, Type I
- 250.60** Diabetes w/ Neurological Manifestations, Type II
- 443.9** Peripheral Vascular Unspecified
- 401.9** Hypertension NOS
- 185** Prostate Cancer
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 Other: _____

2 → I have prescribed a Vacuum Erection Device (CPT/HCPCS Code L7900) It is my expert opinion that a vacuum device is medically necessary to facilitate management of this patients sexual dysfunction. This prescription shall also serve as the Letter of Medical Necessity. By my signature below, I certify that the information contained herein is a true and correct verification of my written order.

Physician Signature

Date

If you fax this document, Medicare / Insurance requirements are that you maintain the signed original in the patient's medical record file for post-payment review audit purposes.

PLEASE INITIAL AND DATE ALL CHANGES

Fax: ~~1-800-859-4795~~

Physician Help Line: 1-800-385-1188



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