

DOCTOR ORDER

Your patient has ordered a Vacume 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	→	<input type="checkbox"/>	607.84 Impotence of Organic Origin (Erectile Dysfunction)
		<input type="checkbox"/>	Other: ICD _____ . ____ Description: _____

SECONDARY DIAGNOSIS	→	<input type="checkbox"/>	250.01 Type 1 IDDM (Insulin Dependent Diabetes Mellitus)						
		<input type="checkbox"/>	250.00 Type 2 NIDDM (Non-Insulin Dependent Diabetes Mellitus)						
		<input type="checkbox"/>	250.61 Diabetes w/ Neurological Manifestations, Type I						
		<input type="checkbox"/>	250.60 Diabetes w/ Neurological Manifestations, Type II						
		<input type="checkbox"/>	443.9 Peripheral Vascular Unspecified						
		<input type="checkbox"/>	401.9 Hypertension NOS						
		<input type="checkbox"/>	185 Prostate Cancer						
		<input type="checkbox"/>	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 15px;"></td> <td style="width: 20px; height: 15px;"></td> <td style="width: 20px; height: 15px;"></td> <td style="width: 20px; height: 15px;"></td> <td style="width: 20px; height: 15px;"></td> <td style="width: 20px; height: 15px;"></td> </tr> </table> 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.

<div style="border: 2px solid black; padding: 5px; display: inline-block; margin-bottom: 5px;">Physician Signature</div> <div style="border-top: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<div style="border: 2px solid black; padding: 5px; display: inline-block; margin-bottom: 5px;">Date</div> <div style="border-top: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
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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



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www.medicoexpress.org

Fax: 1-305-576-7222
Physician Help Line: 1-877-319-9302