877-505-4207 Phone
866-698-9579 Toll Free Fax

ED Vacuum Erection Therapy Prescription

PATIENT INFORMATION		please attach patient demographics
PATIENT NAME:		GENDER: Male
ADDRESS:		
PHONE:	EMAIL:	
SSN:	DOB:	*RX EFFECTIVE DATE:*

PLAN OF CARE

The patient indicated has a diagnosis of Organic Impotence (N52.9) as a result of the following conditions:

____ C61 CARCINOMA OF THE PROSTATE
____ E11.9 TYPE II DIABETES MELLITUS
____ E10.8 TYPE I DIABETES MELLITUS
____ C67.9 CARCINOMA OF THE BLADDER
____ I10 HYPERTENSION
____ C19 COLORECTAL CANCER
____ S34.109A SPINAL CORD INJURY
____ OTHER DX: __________ , __________ , ___________

LENGTH OF NEED	☐ 99 - LIFETIME ☐ OTHER ___________
PATIENT HAS FAILED, HAS CONDRAINDICATION OR HAS INTOLERANCE TO PHARMACOLOGICAL THERAPY	☐ YES ☐ NO ☐ N/A
THERE IS DOCUMENTATION IN THE PATEINT'S MEDICAL RECORDS OF ERECTILE DISFUNCTION	☐ YES ☐ NO ☐ N/A
MOST RECENT DATE PATIENT WAS EVALUATED FOR THE CONDITION	____________ DATE

*****NOTE PLEASE INCLUDE WITH THIS PRESCRIPTION CHART NOTES SPECIFYING A DIAGNOSIS OF ERECTILE DISFUNCTION AS WELL AS PATIENT DEMOGRAPHICS INCLUDING INSURANCE INFORMATION*****

SUPPLIES	HCPCS	QTY	MANUFACTURER PREFERENECE (NOT REQUIRED)
____ ED Vacuum Erection System	L7900	1	
____ Other			

PHYSICIAN INFORMATION		Referral From:
Physician Name		NPI#:
Address		
Phone	Fax	

______________________________ Physician Signature (No Stamps)

______________ Date