Physician's Written Order
Home Phototherapy

3 Depot Street
Hudson Falls, NY 12839
1-800-882-4683
www.uvbiotek.com

Start Date: __ / __ / ____

All fields below are required to process the order. Please print clearly. To be filled out by prescribing physician only.

Patient

First: _____ Last: _____ Middle Initial: _____ DOB: _____

Street Address: _____ Phone: _____ Gender: ☐ M ☐ F

City: _____ ST: ____ Zip: _____ **e-mail**: _____

Prescribing Doctor

Physician Name: _____

Practice: _____

NPI #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ FAX: ( ) _____

Home Phototherapy Product

HCPCs:	Description	Quantity to be dispensed
E0691 ☐	**Hand-held Phototherapy Wand for Scalp, Spot Treatment or Travel. NB - UVB**	1/999 days
E1399 ☐	**Mobile-Lite – Portable NB UVB 2' Phototherapy Panel for Hands and Feet.**	1/999 days
E0693 ☐	**Single Panel with 2, 4, 6, 8 or 10 lamps. 6' Phototherapy Panel with reflective panels**	1/999 days
E0694 ☐	**1600B. (16 NB-UVB Lamps). 6' Phototherapy Full Body Wrap around**	1/999 days
E0694 ☐	**6' MultiDirectional. Single Panel with two Lighted side panels. (10 NB-UVB Lamps).**	1/999 days

Insurance Info

Plan Name: _____

ID#: _____

Group#: _____

Phone#: _____

Additional Information: _____

Home Phototherapy Details

ICD-10: **Description**:

☐ L40.9 Psoriasis
☐ L80 Vitiligo
☐ L30.9 Eczema
☐ ____ _____

Skin Type
☐Type 1 ☐Type II ☐Type III ☐Type IV ☐Type V ☐Type VI

Body Area Affected (Check all that apply)

☐ 3% - 10% (Moderate) ☐ Hands (2%)
☐ > than 10% (Severe) ☐ Feet (2%)
☐ Other ____% ☐ Scalp (9%)

☐ Cumulate: _____

List Previous Treatment: Was it effective?

_____ ☐ Yes ☐ No

Date Treatment Began: ____/____/____

Has Patient ever been treated w/UV Light Therapy in the past? (Either in the office or at home) ☐ Yes ☐ No

If Yes, did the patient benefit from it? ☐ Yes ☐ No

Is the patient and/or caregiver reliable, motivated and able to adhere to instructions? ☐ Yes ☐ No

Reason for Home Use (please check all that apply)

☐ Therapy is Considered Long-Term
☐ Distance and Travel Time to Office
☐ Co-pay Cost of Frequent In-Office Visits
☐ Unable to Take Time Away from Work or School
☐ Other: _____

Signature

I certify that I am the physician identified in this form. I have reviewed the Detailed Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in is true, accurate and complete, to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed or will be trained on the proper use of products prescribed on this written order. The product lists and physician notes and other supporting documentation will be provided to the patient's provider or authorized distributor upon request. I understand any falsification, omission or concealment of material fact, may subject me to civil or criminal liability. By faxiing this form I am acknowledging that the patient is aware that his/her provider and/or authorized distributor may contact them for any additional information to process this order. Acopy of this order will be retained as part of the patient's medical record.

Physician Signature (Required) _____ **Date** _____

(Stamps are not accepted)

DEA# _____

Fax to: 518-747-2294 or e-mail to: info@uvbiotek.com