

CMN for External Vacuum Erection Device, L7900

Patient's Name: _____ HIC#: _____
 Address: _____ DOB: _____

 _____ Insurance Name: _____
 _____ Insurance Phone: _____
 Phone: _____

Your patient has request that we dispense a vacuum erection device for treatment of his erectly dysfunction. The device we dispense will allow him adequate instruction and warning to be effectively managing his condition without invasive medication, injections or surgical procedures. The system includes an instruction manual (in Spanish), education video and toll free-technical support. Your prescription is necessary for the purchase, as well for insurance filling. Please call toll free SS MEDICAL SUPPLY at 1-800-657-4090 if you have any questions.

Thank you,

WRITTEN ORDER FOR EXTERNAL VACUUM ERECTION DEVICE

I prescribe the use of an external vacuum device for the management of organic impotence (607.84 ICD-9 Code) for the patient named above.

Please prescribe patients contributing factors for erectly dysfunction. (i.e. diabetes, heart disease, hypertension, prostate cancer....)

(Narrative required by Medicare)

Physician's Signature: _____ Date signed: ____/____/____

Physician Name: _____ NPI: _____

Address: _____

Physician Phone: _____ Fax: _____