Augusta Medical Systems, LLC

1027 Broad Street P.O. Box 1447 Augusta, GA 30903
Phone: 800-827-8382 Fax: 706-312-0022 Medicare NCS Supplier#: 4694120002

Detailed Written Physician Order, Prescription, & Letter of Medical Necessity

Instructions: Please complete ALL blanks and mail/fax to the address/number at the top of this page. If you fax this document, Medicare and/ or Insurance requires that the providers maintain the signed original in the patient's medical record for post payment review and audit purposes.

Detailed Written Physician Order (Diagnosis below).

Is Patient's erectile dysfunction:

- ☐ 607.84 Organic Impotence
- ☐ 302.72 Non Organic Impotence

The patient has been diagnosed with:

- ☐ 250.00 Non-Insulin Dependent Diabetes Mellitus
- ☐ 250.01 Insulin Dependent Diabetes Mellitus
- ☐ 185 Carcinoma of the Prostate
- ☐ 401.9 Hypertension
- ☐ 952.9 Spinal Cord Injury
- ☐ ______ Other ______________________________

I have prescribed a SomaTherapy-ED Vacuum Erection Device (CPT/HCPCS Code L7900). It is my expert opinion that a vacuum device is medically necessary to facilitate management of this patient's sexual dysfunction. This prescription shall also serve as the Letter of Medical Necessity. Dispense as written.

NPI#: ______________________________

Physician Name: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: __________

Phone: ____________________ Fax: ______________

______________________________ ______________

Physician's Signature Date

Please fax copies of all insurance and Medicare Cards.

HPCPS Code L7900	**Narrative Description of Item(s)** **SomaTherapy-ED** Vacuum Erection Device for treatment of Erectile Dysfunction

Item	Price
☐ Response II® (Manually operated)	$495.00
☐ Touch II® (Battery operated)	$548.00
☐ SOMAerectStf™ (Manually operated)	$595.00
☐ SOMAerectStf Plus™ (Battery & Manual)	$648.00
☐ Shipping	$14.95

(Medicare patients do not include shipping)

Please print legibly:

Patient's Name: ______________________________

Phone Number: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________

Date of Birth: ______________________________

Have you previously purchased a vacuum therapy system? ☐ **Yes** ☐ **No** **If Yes, When?** ___________

Assignment of Benefits (AOB)

I authorize the equipment supplier, Augusta Medical Systems, LLC to file my insurance benefits and obtain medical records pertaining to this claim, and assign payment of benefits to supplier. I understand supplier will file my insurance benefits as a courtesy only, and not as a guarantee of payment. Any amounts provided to me regarding insurance coverage are estimations received from my insurance company by supplier, and are not a guarantee of coverage or payment. I understand I am responsible for paying the supplier any amount not covered by my insurance.

I understand the supplier may use and disclose my protected health information for treatment, payment, and health care operations. In the instance the supplier is out-of-network; I authorize the supplier to refer my health information to a provider that will take assignment of my benefits. I understand the supplier is dedicated to using my health information responsibly and in full compliance with the law.

I acknowledge I have received a copy of the Medicare DMEPOS supplier standards, a copy of the "Buy-Back" program, and Privacy Notice from Augusta Medical Systems.

______________________________ ___________

Patient's Signature Date

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(Orden detallada por Escrito del Médicos, receta y carta de necesidad médica)

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NPI#:____

Physician Name: ___________________________________

Address: ____

City: ________________State: ______Zip: ____________

Phone: __________________ Fax: ____________________

______________________________ ______________

Physician Signature Date

Please fax copies of all insurance and Medicare Cards.

HPCPS Code L7900	Descripción narrativa del (los) artículo(s) SomaTherapy-ED® Dispositivo para la erección por vacío para el tratamiento de la disfunción eréctil

☐ Response II® (operación manual) $495.00

☐ Touch II® (baterías) $548.00

☐ SOMAerect-Stf™ (operación manual) $595.00

☐ SOMAerect-Stf Plus™ (baterías y manual) $648.00

☐ Envío $14.95

(Los pacientes de Medicare no deben incluir el envió)

Por favor en letra de imprenta:

Nombre del paciente: ______________________________

Teléfono: _______________________________________

Dirección: ______________________________________

Ciudad: ____

Estado: _____________________Código: ______________

Fecha de Nacimiento: ______________________________

¿Usted ha comprado previamente un sistema de la terapia del vacío? ☐ Sí ☐ No

Si sí, cuando:____________?

Asignación de Beneficios (AOB)

Autorizo al proveedor de los equipos, Augusta Medical Systems, para que presente el reclamo de mis beneficios ante mi seguro y para que obtenga archivo médicos relacionados con este reclamo; y así mismo le asigno el pago de los beneficios al proveedor. Entiendo que el proveedor presentara el reclamo de mis Beneficios ante mi seguro, únicamente como un acto de cortesía y no como una garantía de pago. Cualesquiera cantidades que me sean provistas, en cuanto a la cobertura del seguro; son estimaciones recibidas de la compañía de seguro por el proveedor y no son una garantía de cobertura o pago. Entiendo que soy responsable de pagar al proveedor, cualquier cantidad no cubierta mi seguro, y que mi firma abajo es la confirmación de la orden que estoy colocando arriba.

Entiendo que el surtidor puede utilizar y divulgar mi información protegida de la salud para el tratamiento, el pago, y las operaciones del cuidado médico. En el caso el surtidor está fuera de red, yo autoriza a surtidor a referir mi información de la salud a un abastecedor que tome la asignación de mis ventajas. Entiendo que dedican al surtidor a usar mi información de la salud responsable y en conformidad completa con la ley.

Me reconozco he recibido una copia de los estándares del surtidor de Seguro de enfermedad DMEPOS, una copia del programa de la "Compra Nueva", y el aviso de la aislamiento de los sistemas médicos de Augusta.

____________________________ ___________

Firma del Paciente Fecha