current technology

M E D I C A R E I N F O R M A T I O N

For Pelvic Floor Electrical Stimulation

(Home Use)

The company that we go through (because we can not bill Medicare – we are not a Medicare provider) has a purchase price of $595.00

- **Please be aware that there are copays that usually apply for Medicare.**
- **Supplemental Insurance companies will usually pick up their portion after Medicare has paid.**

THE FOLLOWING DOCUMENTATION WILL NEED TO BE FAXED TO US:

☐ 1.) **Prescription / Certificate of Medical Necessity Signed by Physician, NP, PA (attached)**

☐ **2.) The referral / prescription / you received from the MD, NP, or PA**

☐ **3.) The face-to-face note from the MD, NP, or PA received at the time of the prescription (#2). If you do not have this documentation and would like us to request it from their office, please check here** ☐

☐ **4.) First physical therapy visit note**

☐ **5.) Clinical-visit note stating that your patient has fecal or urinary incontinence (stress, urge, or mixed) and that he/she has tried and failed (over a 4 week period) an exercise plan prescribed by the physician. Also stating: the patient is cognitively in tact and that you believe the patient will benefit from the e.stim at home.**

Note: This note can be part of your clinical visit note with the patient or a separate note on your letterhead. <u>This will need to be co-signed by a physician, ARNP, PA</u>

☐ **6.) Patient Information Form (Attached)**

☐ **7.) Copy of the patient's insurance card(s)**

☐ **8.) Fax cover sheet should indicate the following:**

1. Where you would like the device shipped (clinic or patient)

2. If your patient needs to purchase a 6330 or 6340 (vaginal or rectal) sensor

Patient Information Form

5851 Duluth Street, Suite 202 Minneapolis,MN 55422
Tel: 800-322-4461 Fax: 763-588-0066

(required for the Pelvic Floor Electrical Stimulator System E0740)
Please complete this form and fax to Current Technology, Inc. at 763-588-0066
If you have any questions, please call us at 800-322-4461

NOTE: A Copy of All Pertinent Medical Records must accompany this form
(Required for Insurance Reimbursement)

Physician Information:

Physician's Name:	Physician's phone:
Physician's Address:	Physician's fax:
NPI:	Diagnosis: N39.46 urge incontinence N39.3 stress incontinence (female)(male) N39.46 mixed incontinence (female) (male) R15.9 Full incontinence of feces (PLEASE CIRCLE) Other: _____

Patient Information:

Patient Name:	Date of Birth:
Street Address:	Social Security Number:
City, State & Zip Code:	
Home phone:	Cell phone:
Name of Spouse:	Emergency Contact / Telephone Number:
Employer:	Business Telephone:
Onset of Symptoms:	**Previously owned Pelvic Floor Stimulator:** YES NO If YES when:
Medications/Treatments:	

Medicare Information:

Primary Insurance:	Insurance Co. phone:
ID/Policy #:	Group #:

Supplemental Insurance Information:

Secondary Insurance Co.:	Secondary Insurance Co. Phone:
Secondary Insurance ID #:	Secondary Insurance Group #:
Subscriber Name:	Subscriber Date of Birth:
Subscriber Social Security Number:	Subscriber Employer:

Patient's Signature_____Date_____

I am responsible for payment of purchase fees that are not paid for or declined for payment by my insurance carrier. If I cannot meet this financial obligation, I will contact S.A. Maher, Inc. at 440-777-5544. I request that my payment from my Medical Insurance Program be made directly to: **S.A. MAHER INC., P.O. BOX 38306 OLMSTED FALLS, OHIO 44138.** I authorize release of medical information when needed. I understand the charge for a Pelvic Floor Stimulation Unit and Sensor is $595.00.

PRESCRIPTION FOR PELVIC FLOOR ELECTRICAL STIMULATOR (E0740)

Patient's Name _____

Patient's Address _____
Street City State Zip

Patient's Phone_____D.O.B._____

The patient has undergone and failed a documented trial of pelvic muscle exercise training prescribed for a

duration of 4 weeks which include _____Yes ☐ No ☐

Previous Treatments / Medications tried:

_____

Are the results documented in the patient's medical notes? Yes ☐ No ☐

(Attach Physical Therapy Notes from week 1 (Co-signature required) and week 4)

Is the patient cognitively intact? Yes ☐ No ☐

Would the patient benefit from home-use with the pelvic floor e.stim? Yes ☐ No ☐

Diagnosis (please circle): N39.41 urge incontinence N39.3 stress incontinence (female)(male)

N39.46 mixed incontinence (female) (male) R15.9 full incontinence of feces

Other: _____

CERTIFICATE OF MEDICAL NECESSITY

The above identified equipment is deemed medically necessary for an estimated period of time below:

- ✓ Purchase
- ✓ No substitutions

Physician's Name _____
(Print)

Address _____
Street City State Zip

Phone_____ Fax_____

NPI_____

Physician's Signature Date