

Physician's Written Order Form  
for Home Phototherapy

Fax completed form, along with **patient's medical records** and **current insurance ID**, to **(216) 765-0271** or email **natbio@natbiocorp.com**

Patient Info:	First Name _____ Last Name _____ DOB ____/____/____ Gender: <input type="checkbox"/> M
	Address _____ City _____ State _____ Zip _____ <input type="checkbox"/> F
	Phone # _____ Email _____
	Parent/Guardian (if minor) _____
<input type="checkbox"/> Check here if the shipping address is same as billing <input type="checkbox"/> Check here for alternate shipping address _____	

Diagnosis:	<b>Diagnosis Code:</b> _____
	<b>Other :</b> _____
(ICD10 code must match the diagnosis code in the patient's medical records)	

Patient Skin Type:	
<input type="checkbox"/> Type I	<input type="checkbox"/> Type IV
<input type="checkbox"/> Type II	<input type="checkbox"/> Type V
<input type="checkbox"/> Type III	<input type="checkbox"/> Type VI

<b>Home Phototherapy Options:</b> (NB-UVB - Only Select One Option) _____ <b>If Other, Please Specify:</b> (if applicable, only write in one choice) _____
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Statement of Medical Necessity (Required For Insurance Approval):	<b>BSA (Body Surface Area) Severity: (Please check all that apply)</b> <input type="checkbox"/> Hands <input type="checkbox"/> Scalp <input type="checkbox"/> Legs <input type="checkbox"/> Chest/Abdomen <input type="checkbox"/> Other <input type="checkbox"/> Feet <input type="checkbox"/> Back <input type="checkbox"/> Full-Body <input type="checkbox"/> Arms
	The reason for this prescription concerns my patient's _____ condition, which affects more than _____ of the patient's body surface area. Patient has a history of _____ which requires immediate treatment to control the disease.
	<b>List Previous Treatments:</b> _____ Was it effective? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date treatment of this condition began: ____/____/____
	Has patient been treated with UV light therapy in the past? <i>(Either in the office or at home)</i> _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, did the patient benefit from the treatment? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Reason For Home Use:</b> <i>(Please check all that apply)</i> <input type="checkbox"/> Therapy is considered long-term <input type="checkbox"/> Previous in-office treatment proved effective <input type="checkbox"/> Patient requires treatment 3x a week <input type="checkbox"/> Drugs or topicals contraindicated or too expensive <input type="checkbox"/> Financial hardship of frequent in-office visits
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<b>Medical Documents:</b> <b>- REQUIRED* -</b> <input type="checkbox"/> Medical records enclosed <input type="checkbox"/> Insurance cards enclosed
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Prescribing Physician Info:	Physician Name _____ Title: <input type="checkbox"/> MD <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> DO
	Practice _____ NPI # _____
	Address _____ City _____ State _____ Zip _____
	Phone # (____) _____ Fax # (____) _____ Email _____

I certify that I am the physician identified on this form. I have reviewed this Physician's Written Order. Any statement on my letterhead attached hereto has also been reviewed and signed by me. I certify that this patient and/or caregiver is capable and will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the product listed, and the physician notes and other supporting documentation will be provided upon request. I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

**Provider Signature (Required)** \_\_\_\_\_

**Date** \_\_\_\_\_

**Signature and date fields must match. (Either both handwritten or both electronically signed. A combination is not permitted.)**

**\*Medical documents are required for prescription processing and must be included upon submission of this form.**

## L20 Atopic dermatitis / Eczema

L20.81 Atopic neurodermatitis  
 L20.82 Flexural eczema  
 L20.84 Intrinsic (allergic) eczema  
 L20.89 Other Atopic Dermatitis  
 L20.9 Atopic dermatitis, unspecified

## L21 Seborrhoeic dermatitis

L21.8 Other seborrhoeic dermatitis  
 L21.9 Seborrhoeic dermatitis, unspecified

## L23 Allergic contact dermatitis

L23.0 Allergic contact dermatitis due to metals  
 L23.1 Allergic contact dermatitis due to adhesives  
 L23.2 Allergic contact dermatitis due to cosmetics  
 L23.3 Allergic contact dermatitis due to drugs in contact with skin  
 L23.4 Allergic contact dermatitis due to dyes  
 L23.5 Allergic contact dermatitis due to other chemical products  
 L23.6 Allergic contact dermatitis due to food in contact with skin  
 L23.7 Allergic contact dermatitis due to plants, except food  
 L23.89 Allergic contact dermatitis due to other agents  
 L23.9 Allergic contact dermatitis, unspecified cause

## L24 Irritant contact dermatitis

L24.0 Irritant contact dermatitis due to detergents  
 L24.1 Irritant contact dermatitis due to oils and greases  
 L24.2 Irritant contact dermatitis due to solvents  
 L24.3 Irritant contact dermatitis due to cosmetics  
 L24.4 Irritant contact dermatitis due to drugs in contact with skin  
 L24.5 Irritant contact dermatitis due to other chemical products  
 L24.6 Irritant contact dermatitis due to food in contact with skin  
 L24.7 Irritant contact dermatitis due to plants, except food  
 L24.81 Irritant contact dermatitis due to metals  
 L24.89 Irritant contact dermatitis due to other agents  
 L24.9 Irritant contact dermatitis, unspecified cause

## L25 Unspecified contact

L25.0 Unspecified contact dermatitis due to cosmetics  
 L25.1 Unspecified contact dermatitis due to drugs in contact with skin  
 L25.2 Unspecified contact dermatitis due to dyes  
 L25.3 Unspecified contact dermatitis due to other chemical products  
 L25.4 Unspecified contact dermatitis due to food in contact with skin  
 L25.5 Unspecified contact dermatitis due to plants, except food  
 L25.8 Unspecified contact dermatitis due to other agents  
 L25.9 Unspecified contact dermatitis, unspecified cause

## L28 Lichen simplex chronicus

L28.0 Lichen simplex chronicus  
 L28.1 Prurigo nodularis  
 L28.2 Other prurigo

## L29 Pruritus

L29.8 Other pruritus  
 L29.9 Pruritus, unspecified

## L30 Other dermatitis dermatitis

L30.0 Nummular dermatitis  
 L30.1 Dyshidrosis [pompholyx]  
 L30.2 Cutaneous autosensitization  
 L30.3 Infective dermatitis  
 L30.4 Erythema intertrigo  
 L30.5 Pityriasis alba  
 L30.8 Other specified dermatitis  
 L30.9 Dermatitis, unspecified

## L40 Psoriasis

L40.0 Psoriasis vulgaris (Nummular psoriasis, Plaque psoriasis)  
 L40.1 Generalized pustular psoriasis (Impetigo herpetiformis, Von Zumbusch)  
 L40.2 Acrodermatitis continua  
 L40.3 Pustulosis palmaris et plantaris  
 L40.4 Guttate psoriasis  
 L40.50 Unspecified Arthropathic psoriasis (M07.0-M07.3\*, M09.0\*)  
 L40.8 Other psoriasis (Flexural psoriasis)  
 L40.9 Psoriasis, unspecified

## L41 Parapsoriasis

L41.0 Pityriasis lichenoides et varioliformis acuta  
 L41.1 Pityriasis lichenoides chronica  
 L41.3 Small plaque parapsoriasis  
 L41.4 Large plaque parapsoriasis  
 L41.5 Retiform parapsoriasis  
 L41.8 Other parapsoriasis  
 L41.9 Parapsoriasis, unspecified

## L42 Pityriasis rosea

## L43 Lichen planus

L43.0 Hypertrophic lichen planus  
 L43.1 Bullous lichen planus  
 L43.2 Lichenoid drug reaction  
 L43.3 Subacute (active) lichen planus  
 L43.8 Other lichen planus  
 L43.9 Lichen planus, unspecified

## L44 Other papulosquamous

L44.0 Pityriasis rubra pilaris  
 L44.1 Lichen nitidus  
 L44.2 Lichen striatus  
 L44.3 Lichen ruber moniliformis  
 L44.4 Infantile papular acrodermatitis [Giannotti-Crosti]  
 L44.8 Other specified papulosquamous disorders  
 L44.9 Papulosquamous disorder, unspecified

## L50 Urticaria

L50.0 Allergic urticaria  
 L50.1 Idiopathic urticaria  
 L50.2 Urticaria due to cold and heat  
 L50.3 Dermatographic urticaria  
 L50.4 Vibratory urticaria  
 L50.5 Cholinergic urticaria  
 L50.6 Contact urticaria  
 L50.8 Other urticarial (Urticaria: chronic, recurrent periodic)  
 L50.9 Urticaria, unspecified

## L63 Alopecia areata

L63.8 Other alopecia areata  
 L63.9 Alopecia areata, unspecified

## L80 Vitiligo

## L92 Granulomatous disorders

L92.0 Granuloma annulare  
 L92.8 Other granulomatous disorders of skin and subcutaneous tissue  
 L92.9 Granulomatous disorder of skin and subcutaneous tissue, unspecified

## L93 Lupus erythematosus

L93.0 Discoid lupus erythematosus (Lupus erythematosus NOS)  
 L93.1 Subacute cutaneous lupus erythematosus  
 L93.2 Other local lupus erythematosus (Lupus: erythematosus profundus, panniculitis)

## L94 Other localized connective tissue disorders

L94.0 Localized scleroderma [morphea] (Circumscribed scleroderma)  
 L94.1 Linear scleroderma (En coup de sabre lesion)

## C84.A0 Cutaneous T-cell lymphoma, unspecified

## C84.00 Mycosis Fungoides

## L11.1 Transient acantholytic dermatosis [Grover's Disease]