

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

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

Home Phototherapy Options: <small>(NB-UVB - Only Select One Option)</small>	_____
If Other, Please Specify: <small>(if applicable, only write in one choice)</small>	_____

Statement Of Medical Necessity <small>(Required For Insurance Approval):</small>	BSA (Body Surface Area) Severity: (Please check all that apply)				
	<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.				
	List Previous Treatments:		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? <small>(Either in the office or at home)</small> <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					

Reason For Home Use: <small>(Please check all that apply)</small>
<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

Medical Documents: - REQUIRED* -
<input type="checkbox"/> Medical records enclosed
<input type="checkbox"/> Insurance cards enclosed

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]