Daavlin

Light Therapy for Seasonal Depression

S.A.D. Solutions

S.A.D. Light Therapy Order Packet

Fax To: 419-636-7916

Mail To: PO Box 626 Bryan, OH 43506

To place your order, follow instructions below. Please print clearly. For assistance, call our representatives at 419-636-6304.

Look on the Bright Side!

At Daavlin, we connect each patient with a Patient Account Specialist who will personally handle every aspect of your order from start to finish.

Whether using your medical insurance or purchasing a home unit out-right, our staff is friendly, professional, and will assist you every step of the way!

Our commitment to you starts...Now!

Here's what we need to begin your order:

From the Patient -

- ☐ Completed "S.A.D. Light Therapy Patient Order Form"
- ☐ Copies of insurance cards (front & back) if using insurance

Helpful Hint: Fill out the online form at Daavlin.com/home-order-form/ with your smart phone and take pictures of your insurance card

From the Prescriber -

- ☐ Completed and signed "Physician's Written Order Form"
- ☐ Five to ten pages of relevant chart notes for insurance approval (if patient is using insurance)

Helpful Hint: Use our online prescriber's portal at ClearLink.Daavlin.com to write prescriptions, upload chart notes, & create instructions

Simply send these items to Daavlin and we can get started!

- Fax to 419-636-7916 or 419-636-1739
- Mail to Daavlin, PO Box 626, Bryan, OH 43506
- Email to phototherapy@daavlin.com
- Online Patient Order Form is available at www.daavlin.com

All patient paperwork is kept confidential. Once we receive your complete information, one of our friendly and experienced Patient Account Specialists will contact you to discuss your order.

If you have questions or require immediate assistance, call Daavlin now at 419-636-6304. Our team is ready to assist you!

Brighter days are coming!

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Daavlin
Light Therapy for Seasonal Depression
S.A.D. Solutions

Physician's Written Order for S.A.D. Light Therapy

Fax to Daavlin: 419-636-7916. Call 1-800-322-8546 for assistance.

Rx Prescriber Instructions: This form is a Prescription and Letter of Medical Necessity for SAD home light therapy units. All fields are required.

Patient Info:

First Name _____ Last Name _____ DOB ____/____/____ Gender: ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Phone # _____ Alt Phone # or Email _____

Prescribing Physician Info:

Physician Name _____

Practice _____

NPI# _____

Address _____

City _____ State ____ Zip _____

Phone (____)_____ Fax (____)_____

Product:

	HCPCs:	Description:
☐	E0203	Table-top, high-intensity, bright light therapy unit. 10,000 LUX

Treatment Information:

Prescribed Therapy:

☐ Bright light therapy administered by a high-intensity light therapy unit (E0203) at an approximate distance of 10-12 inches, 30 minutes per treatment, once daily in the morning for at least one week at onset of symptoms.

☐ Other: _____

_____

_____

_____

Physician Signature:

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.

Physician Signature and Title Required (No Stamps Please!)

_____ ☐ MD ☐ DO ☐ PA ☐ NP

Date_____

Statement of Medical Necessity:

Diagnosis: _____

ICD-10: _____

☐ Meets the Criteria for Seasonal Pattern Specifier

☐ Other _____

Estimated Duration of Need: 99 Months or Other: ___ *(99 = Lifetime)*

Is the patient and/or caregiver reliable, motivated and able to adhere to instructions? ☐ Yes ☐ No

Please check all that apply:

- ☐ Regularly occurring symptoms of depression in fall and winter months
- ☐ Remission of symptoms in spring and summer months
- ☐ Seasonal depressive episodes outnumber the non-seasonal depressive episodes
- ☐ Decreased activity
- ☐ Fatigue, heavy feeling in arms and legs
- ☐ Sadness
- ☐ Anxiety
- ☐ Increased appetite, cravings for sweets or starches
- ☐ Weight gain
- ☐ Social withdrawal
- ☐ Hypersomnia, tendency to over-sleep
- ☐ Irritability
- ☐ Other: _____
- ☐ Other: _____

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Light Therapy for Seasonal Depression
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S.A.D. Light Therapy Patient Order Form

Fax To: 419-636-7916 Mail To: PO Box 626 Bryan, OH 43506

To be filled out by the PATIENT. Please print clearly. For assistance, call 1-800-322-8546.

Patient Info:

Patient Name_____ Phone_____

Address_____ City_____ State_____ Zip_____

Request & Consent for Daavlin to Communicate by Email: Email Address_____

Date of Birth_____ Gender: ☐ Male ☐ Female Text/Phone_____

If Under 18, Parent/Guardian Name_____ Phone_____

Purchase Info:

☐ Daavlin Free Insurance Assistance: *(Prescription Required for Insurance Coverage)*

Daavlin and/or Daavlin's In-Network Billing Agent will verify your insurance eligibility and benefits and contact you before processing your order. Copy of insurance card required.

☐ Purchase Without Insurance Using: *(No Prescription Needed for OTC Use)*

☐ *Check* ☐ *Credit Card* ☐ *Daavlin Payment Plan (50% Deposit Required)*

Insurance Information and Confirmation: (Required for Free Insurance Assistance)

Primary Insurance Company_____

Insurance ID Number _____

Insurance Phone Number (Found on card)_____

Policy Holder Name_____Date of Birth_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policy Holder Phone Number_____

Employer_____ Group / Plan Number_____

Secondary Insurance Company, if any_____

Insurance ID Number _____

Insurance Phone Number (Found on card)_____

Policy Holder Name_____Date of Birth_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policy Holder Phone Number_____

Employer_____ Group / Plan Number_____

By completing this section, I authorize Daavlin or its billing agents to verify my insurance benefits for DME. I authorize direct billing to my insurance, assignment of benefits to Daavlin or its billing agents and release of medical records necessary to process my insurance claim. I understand there is no obligation to purchase to receive free verification of my insurance benefits, but once I instruct Daavlin or its billing agent to ship my order, payment in full is my responsibility.

Product Selection:

☐ ***E0203 - BrighterDays PLUS:***

BrighterDays PLUS includes a built-in, digital timer allowing you to select a treatment time at the touch of a button. It provides 10,000 LUX at a 10-12 inch treatment distance.

10.6 IN H X 8.2 IN W X 3.1 IN D, 1.8 LBS

☐ ***E0203 - TraveLite:***

TraveLite's streamlined shape gives it a bright, modern look. It provides 10,000 LUX at a 10-12 inch treatment distance.

13 IN H X 7 IN W X 2.6 IN D, 2.5 LBS

Shipping & Order Confirmation:

- It is important to understand the size and weight of your prescribed device and the shipping process, as all sales of medical devices are final. Please discuss these details with your Patient Account Specialist by calling 1-800-322-8546.
- The cost of delivery is included in the price of the unit when shipped in the contiguous 48 States, and consists of basic carriage to a ground floor door of your home or garage. Deliveries to Alaska and Hawaii will be provided a quote prior to shipping.

Important! Here are the items Daavlin needs to begin processing your order:

☐ Patient Order Form (This page, signed by the patient) ☐ Physician's Written Order (Must be completed by your prescriber) and Chart Notes (only if using insurance)

I confirm that the above information is accurate and complete to the best of my knowledge. I understand that a Physician's Written Order Form and chart notes (if using insurance) must accompany my order. I have read, understand and agree to Daavlin's Terms and Conditions of Sale Agreement (page 3) and I understand that all sales of medical equipment are final. I agree to follow my prescriber's instructions for proper use of this medical device.

Patient Signature (Required)_____ Date_____

If patient is under age 18, parent/guardian signature is required.

Terms & Conditions of Sale Agreement

Please read the following information carefully and keep this document for your records. For questions, call 1-800-322-8546.

Daavlin
Let's Be Clear

- Daavlin home medical devices are sold only by prescription or written order of a licensed physician.

- You agree to use your home medical device only in the manner in which it was intended. This includes following your physician's instructions, scheduling periodic follow-up examinations and using recommended safety procedures during treatments. Minor patients for whom devices are prescribed are required to be under the supervision of a parent or guardian who understands the use of the device and assumes full responsibility of the minor.

- You agree that all sales of prescription medical equipment are non-returnable, therefore all sales are final. Any returns must be pre-approved and will incur a service fee. Daavlin is not responsible for shipping charges.

- Daavlin's HIPAA Privacy Policy, Medicare Standards, and Patient Bill of Rights are available on www.daavlin.com, and a printed copy will be included with your device upon shipment. To receive an additional copy by fax, mail or email, call your representative at 1-800-322-8546.

- When Free Insurance Assistance is requested, Daavlin evaluates your insurance network. If Daavlin is "Out of Network" for your health plan, and it would financially benefit you to use an "In Network" provider, Daavlin may recommend one of its authorized distributors who is in your network. In this situation, the distributor would act as an in network provider / billing agent. All distributors are companies who provide Daavlin products and are licensed to provide and bill for Durable Medical Equipment.

- There is no obligation to purchase when Daavlin or its billing agent verifies your insurance benefits and eligibility. However, once you have authorized shipment of your order, payment in full of the agreed upon price becomes your responsibility. You understand that unmet deductibles, co-pays and changes in plan benefits can sometimes affect the amount of reimbursement you receive and you agree to pay the difference between the agreed upon price and the amount of your insurance reimbursement.

- If your device has not yet been paid in full, and your insurance company sends its payment to you instead of to Daavlin or its billing agent, you agree to forward this payment to Daavlin or the billing agent within five business days of receipt.

- Only orders within the contiguous 48 states qualify for Daavlin's "Standard" delivery. Hawaiian and Alaskan deliveries will incur additional shipping charges, as will addresses that require a special delivery via box truck instead of a standard freight semi truck. Daavlin will provide shipping quotes based upon the delivery address.

- Daavlin's "Standard Delivery" (no extra cost) only includes carriage of the device to the ground floor door of your home or garage. You may request a quote for "White Glove Delivery" if you desire additional delivery services such as stair carry.

- Upon delivery to your home, you agree to inspect the package and to note any damage on the freight receipt prior to accepting the delivery. If you are unable to fully inspect the product before signing off on the delivery, you agree to indicate "Further Inspection Required - Concealed Damage Possible" on the freight receipt and to notify Daavlin within two business days of the product being delivered, if any damage is present.

- You agree that you have read and fully understand the size and weight of the device and that you have space to accommodate it. Further, you confirm your understanding that some larger devices may require a special electrical outlet and that you may have to have this wiring installed for the device to operate. (Information on size, weight and electrical requirements can be found on our web site at www.daavlin.com or you may call a Daavlin representative at 1-800-322-8546).

- You understand, as the purchaser, that signing the Patient Order Form document constitutes your understanding and agreement to the terms and conditions contained herein, which are applicable to the purchase of Daavlin home medical products.