



Aquex Iontophoresis 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 1-800-322-8546.



Aquex

Tap Water Iontophoresis
for the Treatment of Hyperhidrosis

Don't Sweat It!

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 "Aquex Home Patient Order Form"

From the Prescriber -

- Completed and signed "Prescription & Written Order for Aquex"
- Five to ten pages of relevant chart notes for insurance approval (if patient is using insurance)

Helpful Hint: Prescriptions can also be securely submitted using our online prescriber's portal at ClearLink.Daavlin.com

Simply send these three 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 aquex@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 1-800-322-8546. Our team is ready to assist you!

It's Time to Take Control!

Aquex Home Patient Order Form

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

Please print clearly. For assistance, call our representatives at 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: *(Copy of both sides of insurance card required)*
Daavlin and/or Daavlin's In-Network Billing Agent will verify your insurance eligibility and benefits and contact you before processing your order.
- Purchase Without Insurance Using:
 - 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:



Aquex™ Home System Tap Water Iontophoresis

System Includes: 1 Aquex digital control module, 1 carrying case / treatment tray, 1 AC adapter with plug, red and black electrode cables, 2 aluminum electrodes, and 2 dye-free, cotton treatment towels. Treats both hands and /or feet.

Optional Accessories:

- Small Electrodes (for accessory pads) 15.00
- Axillary (Underarm) Pads 40.00
- Neck Pad 90.00
- Back/Chest Pad 90.00
- Replacement Towels 20.00

Prescriptions are required for all device orders. Optional add-ons and accessories are not covered by insurance and are billed separately.

Shipping & Order Confirmation:

- It is important to understand your prescribed device and the shipping process, as all sales of prescription 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 3 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) Chart Notes (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 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.



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 (____) _____

Tap water iontophoresis is a recognized medical therapy for treatment and control of hyperhidrosis. Aquex is cleared by the FDA as a medical device for the treatment of palmar, plantar, or axillary hyperhidrosis, and can be ordered only by a prescription from the patient's provider.

This patient meets the criteria for:

- Hyperhidrosis:**
 Abnormally excessive sweating in the hands (palmar), feet (plantar), or axillary (under arms).

Date of Diagnosis: ____/____/____

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

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

Please indicate ICD-10 Diagnosis Code:

L74.51 - Primary Focal Hyperhidrosis

- L74.510 Axilla L74.512 Palms
 L74.513 Soles L74.519 Unspecified
 Other: _____

Statement of Medical Necessity:

Hyperhidrosis (excessive sweating) has a devastating effect on a patient's quality of life, causing physical discomfort, social embarrassment, and disruption of occupational and daily activities. This has been true for this patient who has suffered from hyperhidrosis for a significant length of time. Experts recommend a stepped approach to choosing therapy for hyperhidrosis. Tap water iontophoresis (TWI) is safe, effective, and has long been known to inhibit sweat production. It is the next logical choice for treating this patient's condition. Continued treatment is required to maintain effectiveness, therefore I am recommending the purchase of an Aquex personal home TWI device. It is economical and will provide long term treatment for this patient. If denied, other treatment options include continuous Botox injections or surgery (Sympathectomy). In light of this clinical information and the patient's condition, tap water iontophoresis is medically necessary and warrants insurance coverage.

Statement of Medical Necessity (Required for Insurance Approval):

HCPCS: Product and Description:

E1399 Aquex™ Home System Tap Water Iontophoresis

Includes: 1 Aquex digital control module, 1 carrying case / treatment tray, 1 AC adapter with plug, red and black electrode cables, 2 aluminum electrodes, and 2 dye-free, cotton treatment towels.

Product Prescribed:

Treatment Info:

- Use 3 times weekly for 4 weeks, then reduce frequency to a 1 - 2 times per week maintenance regimen.
 Use 10 days in a row, then reduce frequency to a 1 - 2 times per week maintenance regimen.
 Other: _____

Prescriber Signature:

I certify that I am the provider 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) _____ Title MD DO PA NP Date _____

(Stamps are NOT acceptable)

(Provider's title and Rx date are required)