Daavlin

Home Phototherapy Featuring

ClearLink Control

Home Phototherapy 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.

Let's Be Clear...

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 "Home Phototherapy Patient Order Form"

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: 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 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 1-800-322-8546. Our team is ready to assist you!

It's Time to Live Clear!

Daavlin
Home Phototherapy Featuring
ClearLink Control

Home Phototherapy 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: *(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 (Default is Base Model):

☐ ***E0691 -*** *DermaPal:*
Hand-held treatment wand for scalp, spot treatment or travel. Includes comb attachment, goggles and carrying case.

☐ ***E0691 -*** *1 Series 4 lamp:*
Small, light-weight panel for hands, face, feet, elbows, or other localized treatment area.

☐ ***E0694 -*** *7 Series 8 lamp:*
Six foot tall phototherapy unit with multi-directional lamps for large areas and/or full body treatment.

E0694 Optional Upgrade:

☐ 7 Series 10 lamp ☐ UV Series 12 lamp
☐ 7 Series 12 lamp ☐ UV Series 16 lamp
☐ UV Series 24 lamp

☐ Accessories: _____
☐ Extended Warranty Plan
☐ E0692 - 4 Series 10 lamp - Cash Sale Only
☐ E0692 - 4 Series 20 lamp - Cash Sale Only
☐ E1399 - M Series 10 lamp
☐ E1399 - Levia UVB Select
☐ Other: _____

Prescriptions are required for all device orders. Device type, controller mode and lamp type are based upon the prescription. Optional add-ons and upgrades from base model devices are not covered by insurance and are billed separately.

Shipping & Order Confirmation:

- It is important to understand the size and weight of 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 or those requiring a box truck 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
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.

Daavlin
Home Phototherapy Featuring ClearLink Control

Physician's Written Order for Home Phototherapy

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

Rx This form is a Prescription and Statement of Medical Necessity for Daavlin home phototherapy devices. (For Levia orders, FlexRx refills, and replacement lamp Rxs, please use the appropriate forms.) **All fields required for insurance approval.**

Patient Info:

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

Address _____ City _____ State _____ Zip _____

Phone # _____ Alt Phone # or Email _____

Home Phototherapy Product:

HCPCs:		Product and Description:
E0691	☐	**DermaPal:** Hand-held treatment wand for scalp, spot treatment or travel. Includes comb attachment.
E0691	☐	**1 Series:** Small, light-weight panel for hands, face, feet, elbows, or any other localized treatment area.
E0694	☐	**7 Series/UV Series:** Six foot tall, multi-directional unit for large areas and/or full body treatment.
_____	☐	Other: _____

Prescribing Physician Info:

Physician Name _____

Practice _____

NPI# _____

Address _____

City _____ State ____ Zip _____

Phone (____)_____ *Fax (____)_____

** IMPORTANT: We will use this fax number to fax Dosing Guides when requested*

Diagnosis:

ICD-10 Code Must Be Indicated

ICD-10 Code:		Description:
L40 . 9	☐	Psoriasis, Unspecified
L40 . ___	☐	Psoriasis: _____
L80	☐	Vitiligo
____ . ___	☐	Other: _____

Helpful Tip: See back of page for ICD -10 Code Quick Reference Guide

Prescription:

Prescribed Lamp Type: ☐ NB UVB ☐ Other_____

FlexRx: *(Exposure Limiting Software)* ☐ No ☐ Yes, # of exposures: ____

*FlexRx can be prescribed in **increments of 10** up to 250; if not specified, the default qty is 40.*

New! ClearLink Control Mode: *If not specified, the default mode is Time Only.*

☐ Prescription Guided Mode: Controller is pre-programmed with Dose/Rx

☐ Dosimetry Only Mode ☐ Time Only Mode *(All DermaPal Devices)*

Dosing Instructions:

Patient's Fitzpatrick Skin Type and Starting Dose:

Vitiligo & ☐ Type I	☐ Type II	☐ Type III	☐ Type IV	☐ Type V	☐ Type VI
200 mJ	*300 mJ*	*400 mJ*	*500 mJ*	*700 mJ*	*800 mJ*

Treatment Frequency:

☐ Every Other Day	☐ 2 X per Week	☐ 3 X per Week	☐ 4 X per Week	☐ Other:_____

If skin is not pink at time of next treatment, increase dose by:

☐ 10%	☐ 15%	☐ 20%	☐ Other:_____

Other Instructions:_____

☐ Daavlin Phone Training OR ☐ Fax Dosing Guide, Provider Will Instruct Patient

Statement of Medical Necessity (Required for Insurance Approval):

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

BSA (Body Surface Area) and Severity: *(Please check all that apply)*

Percentages are totaled to calculate the severity level.

Greater than 10% = **Severe** 3% to 10% = **Moderate** Less than 3% = **Mild**

☐ Hands	2%	☐ Chest/Abdomen	18%	Total BSA:
☐ Feet	2%	☐ Arms	18%	
☐ Scalp	9%	☐ Legs	18%	_____%
☐ Back	18%	☐ Other _____	___%	

List Previous Treatments: Was it Effective?

_____ ☐ Yes ☐ No

_____ ☐ Yes ☐ No

Date Treatment of this Condition Began: ____ / ____ / ____

Has patient been treated w/ UV Light Therapy in the past? (Either in the office or at home). . . . . ☐ Yes ☐ No

If yes, did the patient benefit from it?. . . . . ☐ Yes ☐ No

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

Reason for Home Use: *(Please check all that apply)*

- ☐ Therapy is Considered Long-Term
- ☐ Drugs or Topicals are Contraindicated or Too Expensive
- ☐ Distance and Travel Time to Office
- ☐ Co-pay Cost of Frequent In-Office Visits
- ☐ Unable to Take Time Away from Work or School
- ☐ Other:_____

Prescriber 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.

Provider Signature (Required)_____ Title ☐ MD ☐ DO ☐ PA ☐ NP Date_____

(Stamps are NOT acceptable) (Provider's title and Rx date are required)

Quick Reference Guide:
Commonly Used ICD-10 Codes

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 dermatitis
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 and prurigo
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
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 disorders
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 of skin and subcutaneous tissue
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.A Cutaneous T-cell lymphoma, unspecified
L11.1 Transient acantholytic dermatosis [Grover's Disease]