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!
Home Phototherapy Patient Order Form

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

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________________________

☐ 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)

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 CL 4:
Small, light-weight panel for hands, face, feet, elbows, or other localized treatment area.

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

E0694 Optional Upgrade:
☐ 7 Series CL 10 ☐ UV Series CL 12
☐ 7 Series CL 12 ☐ UV Series CL 16
☐ UV Series CL 24

☐ Accessories:
☐ Extended Warranty Plan
☐ E0692 - 4 Series CL 10 - Cash Sale Only
☐ E0692 - 4 Series CL 20 - Cash Sale Only
☐ E1399 - M Series CL 10
☐ 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.

• 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 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________________
• 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 restocking 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 will 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. 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:

<table>
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<th>First Name</th>
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<th>DOB</th>
<th>Gender</th>
<th>Address</th>
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### Diagnosis:

**ICD-10 Code:**

- L40. __________ Psoriasis
- L80. __________ Vitiligo
- Other: ________

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

### HCPCs:

- 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: __________

### Prescription Information:

**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:**

- Prescription Guided Mode: Controller is pre-programmed with Dose/Rx
- Dosimetry Only Mode
- Time Only Mode (All DermaPal Devices)

### Patient's Fitzpatrick Skin Type and Starting Dose:

**Type I** 200 mJ
- Type II 300 mJ
- Type III 400 mJ
- Type IV 500 mJ
- Type V 700 mJ
- Type VI 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: __________

### Dosing Instructions:

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

### Physician Info:

**Physician Name:**

Practice

NPI# __________

Address

City __________ State __________ Zip __________

Phone (____) __________ *Fax (____) __________

*IMPORTANT: We will use this fax number to fax the Prescriber's Dosing Guide*

### Estimated Duration of Need:

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

**Body Area Affected:**

- 3% - 10% (Moderate) Hands (2%)
- > than 10% (Severe) Feet (2%)
- Other: __________%

**List Previous Treatments:**

Was it Effective?

- Yes
- No

**Reason for Home Use:**

- 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: __________

**Date Treatment 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

### Statement of Medical Necessity:

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 (Required)** __________

(Date)

(Stamps are not acceptable)
### L00 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

### L10 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

### L20 Atopic dermatitis / Eczema
- **L40.2** Acrodermatitis continua
- **L40.81** Atopic neurodermatitis
- **L40.3** Pustulosis palmaris et plantaris
- **L40.82** Flexural eczema
- **L40.84** Intrinsic (allergic) eczema
- **L40.89** Other Atopic Dermatitis
- **L40.9** Psoriasis, unspecified

### L21 Seborrhoeic dermatitis
- **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

### L22 Other dermatitis
- **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

### 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

### L43 Lichen planus
- **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 acrodernatitis [Giannotti-Crosti]
- **L44.8** Other specified papulosquamous disorders
- **L44.9** Papulosquamous disorder, unspecified

### L44 Other papulosquamous disorders
- **L45** Unspecified dermatitis
- **L45.0** Nummular dermatitis
- **L45.1** Dyshidrosis [pompholyx]
- **L45.2** Cutaneous autosensitization
- **L45.3** Infective dermatitis
- **L45.4** Erythema intertrigo
- **L45.5** Pityriasis alba
- **L45.8** Other specified dermatitis
- **L45.9** Dermatitis, 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

### 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

### L52 Alopecia areata
- **L53** Alopecia totalis
- **L53.0** Alopecia totalis
- **L53.1** Alopecia Universalis
- **L53.2** Alopecia totalis et universalis
- **L53.9** Alopecia areata, unspecified

### L54 Other alopecia areata
- **L55** Alopecia totalis
- **L55.0** Alopecia totalis
- **L55.1** Alopecia Universalis
- **L55.2** Alopecia totalis et universalis
- **L55.9** Alopecia areata, unspecified

### L60 Vitiligo
- **L61** Vitiligo
- **L61.0** Vitiligo with depigmentation
- **L61.1** Vitiligo without depigmentation
- **L61.2** Vitiligo with depigmentation
- **L61.9** Vitiligo, unspecified

### L64 Other localized connective tissue disorders
- **L64.0** Localized scleroderma [morphea] (Circumscribed scleroderma)
- **L64.1** Linear scleroderma (En coup de sabre lesion)
- **L64.8** Other specified localized connective tissue disorders
- **L64.9** Localized connective tissue disorder, unspecified

### L80 Vitiligo
- **L82** Granulomatous disorders of skin and subcutaneous tissue
- **L82.0** Granuloma annulare
- **L82.8** Other granulomatous disorders of skin and subcutaneous tissue
- **L82.9** Granulomatous disorder of skin and subcutaneous tissue, unspecified

### L90 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)
- **L93.8** Other specified lupus erythematosus
- **L93.9** Lupus erythematosus, unspecified

### L99 Other localized connective tissue disorders
- **L94.0** Localized scleroderma [morphea] (Circumscribed scleroderma)
- **L94.1** Linear scleroderma (En coup de sabre lesion)
- **L99.9** Other localized connective tissue disorder, unspecified

### C84.1 Cutaneous T-cell lymphoma, unspecified
- **L11.1** Transient acantholytic dermatosis [Grover’s Disease]