Prescription For Home Phototherapy

eMail to______________

Patient

First Name_________ Last Name__________ Middle Initial___

Date Of Birth____/____/____ Gender ☐ M ☐ F

Address____

City_____________ State________ Zip___________

Phone______________________________

Prescribing Doctor

Physician Name_____________________________________

Practice____

NPI#____

Address____

City_________________ State________ Zip___________

Phone_____________________ Fax____________________

Diagnosis & Statement of Medical Necessity

	ICD-9	Deccription
☐	696.1	Psoriasis
☐	709.01	Vitiligo
☐	______	_________

Body Area Affected

☐ 3 % - 10 % (Moderate) ☐ Hands (2 %)

☐ > than 10 % (Severe) ☐ Feet (2 %)

☐ Other_______% ☐ Scalp (9 %)

Cumulate___________________________________

List Previous Treatments	Was it Effective?	
_____________________________	☐ Yes	☐ No
_____________________________	☐ Yes	☐ No
_____________________________	☐ Yes	☐ No

Date Treatment Began____/____/____

Has patient ever 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

Unit Info

Prescribed Lamp Type

☐ NB UVB ☐ UVA ☐ __________

Home Phototherapy Product

Model		Description
KN-4003BL	☐	Hand-held or portable ultraviolet light-emitting medical device, consists of a LCD, 7 buttons, an integrated comb and a lamp wand, for Scalp, Spot Treatment
KN-4003B	☐	Hand-held or portable ultraviolet light-emitting medical device, consists of an integrated comb and a lamp wand, for Scalp, Spot Treatment
KN-4006BL	☐	Hand-held or portable ultraviolet light-emitting medical device, consists of a LCD, 7 buttons, and a lamp wand, for Hands, Feet, Face and Other Localized Area
KN-4006B	☐	Hand-held or portable ultraviolet light-emitting medical device, consists of a LED, 3 buttons, and a lamp wand, for Hands, Feet, Face and Other Localized Area

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 (Required)____ Date____________________

(Stamps are not acceptable)