MEDICAL ORDER (CERTIFICATE OF MEDICAL NECESSITY)

This is a request for *Leva*® Pelvic Health System (HCPCS: S9002).

PATIENT INFORMATION REQUIRED

Patient Name (First & Last):		Date of Birth:
Address (Street, City, State, Zip):		Phone #:
Patient E-mail:		Language Preference:
Primary Insurance:	Member ID:	Group ID:

PRESCRIBER INFORMATION

Prescriber Name:	NPI:
Practice Name:	Tax ID:
Practice Address:	Phone #:
Office Contact (Name & E-mail):	Fax #:

PRESCRIBER ORDER FOR LEVA PELVIC HEALTH SYSTEM (must be completed by prescriber or prescriber's staff)

DIAGNOSIS AND ICD-10 CODES

☐ N39.3 Stress Incontinence
☐ N39.41 Urgency Incontinence
☐ N39.46 Mixed Incontinence
☐ N32.81 Overactive Bladder
☐ R15.9 Fecal Incontinence
☐ Other:_____

SUPPORTING CLINICAL SYMPTOMS (Check all the apply)

Leakage
☐ Leaking from coughing, sneezing, laughing
☐ Leaking from lifting or exercising
☐ Involuntary voiding after sudden urge
☐ Leaking during sleep

Urgency
☐ Frequent urination during the day
☐ Sudden urinary urgency
☐ Frequent nighttime urination

Incontinence Impact to Patient
☐ Anxiety and/or depression
☐ Limits ability to exercise
☐ Sleep disruption from urge/leaking
☐ Pad use, soiled garments, odor

PRIOR INTERVENTIONS (Check all that apply)
☐ Pelvic Floor Muscle Exercises
☐ Pelvic Floor Physical Therapy
☐ Habit/Bladder Training / Scheduled Voiding
☐ Vaginal Pessary/Urethra Bulking Injections
☐ Surgical Procedure
☐ Other: _____

***Leva*® Pelvic Health System - 1st-line Pelvic Floor Muscle Therapy (PFMT) treatment and monitoring for urinary or fecal incontinence.**

Quantity: 1 with PRN replacements for 12 months. If other, specify: _____

Directions for Use: Use twice daily (am & pm), approximately 2.5 minutes each time following app therapy. Remove after each use.
If different directions for use apply, please indicate: _____

I certify I am the Prescriber identified on this form and authorized by law to order the product requested herein. I also certify the prescribed treatment is medically necessary, reasonable and appropriate according to accepted standards within the medical community for the treatment of the patient's diagnosed condition.

PRESCRIBER SIGNATURE _____ ***DATE*** _____

OFFICE INSTRUCTIONS. PLEASE FAX/EMAIL ALONG WITH CLINICAL NOTES AND INSURANCE INFORMATION.

Please send FULLY completed SIGNED & DATED *Leva* order form

by Fax: 877.800.4371 or by Email (.pdf file): fax@levacares.com