



HOW TO ORDER:

- We can help you regain control of your sexual performance and satisfaction today.
- Please provide us with the following information and have your physician fill out and process the attached form. All information must be complete prior to shipment.
- You can also call a patient support specialist at (888) 503-2481 to assist with any questions.
- We will help you complete your order form, obtain your prescription and file your Medicare claim.
- If you do not qualify for a reimbursed unit, please visit www.postvac.com for over the counter options.

Patient Information

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Birth Date: _____ Medicare Policy Number: _____

Secondary Insurance Company Name: _____ Phone: _____

Plan/Group #: _____ Secondary Policy Number: _____

The Assignment of Benefits

Patient Signature Required.: _____ Date: _____

I authorize the equipment supplier to file for my insurance benefits for my purchase. If you have Medicare Part B, you only need to fill out the form (completely), and mail/fax it back in with a copy of your Medicare card (front and back) and a patient support specialist will contact you to process your order.

*You are responsible for paying Pos-T-Vac the total amount of your unmet Medicare deductible or any amount not covered by insurance. Proof of paid deductible is required. We cannot bill through an HMO without prior authorization. You must sign and date the Assignment of Medicare Benefits section (see above).

Complete your product selection

- Erec-Tech M.O.S. Erec-Tech B.O.S. Erec-Tech Advantage \$75 upgrade

Have your physician complete the prescription form.

Vacuum Therapy System Prescription Form DO NOT SUBSTITUTE. DISPENSE AS WRITTEN

The patient indicated below has been diagnosed with:

- 607.84 Organic Impotence 952.9 Spinal Cord Injury 188.9 Carcinoma of Bladder Other _____

This erectile dysfunction is a result of:

- 185.0 Carcinoma of the Prostate 250.00 Diabetes Mellitus 401.9 Hypertension

Yes No There is documentation of Medical Notes Supporting Erectile Dysfunction. Please supply notes with prescription.

Most Current Date was evaluated for the condition of Erectile Dysfunction or Organic Impotence: _____

This Vacuum Therapy System is medically necessary for the above diagnosis.

Physician Name: _____ NPI# _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

"I prescribe and request this vacuum therapy system for my patient named above because the vacuum therapy system is medically necessary."

I have reviewed the above information for completeness and accuracy.

Physicians Signature: _____ Date: _____

Fax or Mail all completed information and copies of insurance cards (front & back) with the prescription:

Pos-T-Vac Medical • 4811 Technology Drive • Augusta, GA 30907 • Fax: (800) 316-9254 • Postvac.com