



## CERTIFICATE OF MEDICAL NECESSITY

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Please complete all blanks and fax/mail to the number/address listed below.

### ERECAID VACUUM ERECTION DEVICE ( L7900 )

<input type="checkbox"/>	607.84	Organic Impotence
<input type="checkbox"/>	401.9	Hypertension
<input type="checkbox"/>	250.00	Non-Insulin Dependent Diabetes Mellitus
<input type="checkbox"/>	250.01	Insulin Dependent Diabetes Mellitus
<input type="checkbox"/>	185	Carcinoma of the Prostate
<input type="checkbox"/>	188.9	Carcinoma of the Bladder
<input type="checkbox"/>	154.0	Colorectal Carcinoma

I have prescribed the ERECAID Erection Device. It is my expert opinion that a vacuum device is medically necessary to facilitate management of this patient's sexual dysfunction.

Physician: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

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**PLEASE FAX THIS FORM TO 1-877-699-6037**