Insurance Coverage Checklist

Dear Provider,

Please submit the following information to us to obtain insurance coverage for a Fischer Iontophoresis unit for your patient.

Via email: info@rafischer.com

Via fax: 818-775-2941

- Completed Patient Information Sheet
- Copy of the front and back of your insurance card (please attach)
- Prescription and/or Completed “Authorization Form For The R.A. Fischer Iontophoresis Device”
- Letter of Medical Necessity on Office Letter Head (template)
- Completed Hyperhidrosis Preauthorization Request Form
- Pertinent Medical Chart History (please attach)

Note to Providers: If submitting documentation for your patient, please include patient contact information and copies of the front and back of patient insurance card.
# Patient Information Sheet

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________</td>
<td>_______________________</td>
</tr>
</tbody>
</table>

**CONTACT INFORMATION:**

<table>
<thead>
<tr>
<th>Address:</th>
<th>Email Address:</th>
<th>Patient Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>______________</td>
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</tbody>
</table>

**INSURANCE INFORMATION:**

<table>
<thead>
<tr>
<th>Plan Name:</th>
<th>Member ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________</td>
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<table>
<thead>
<tr>
<th>Policy Holder Name:</th>
<th>Policy Holder DOB:</th>
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<tr>
<td>___________________</td>
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**PLEASE ATTACH COPIES OF FRONT & BACK OF PATIENT INSURANCE CARD**

**Authorization to assign benefits to the Provider and Release of Medical Information**: I request that payment of authorized benefits be made on my behalf to AR Hinkel Co, Inc./RA Fischer Co. and affiliates for products or services that they may have provided to me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical related information about me to be released to the Health Care Finance Administration or other health care coverage entity, any information for this or any related health care claim in writing or verbally. I also authorize my insurance company(ies) to furnish to an agent of AR Hinkel Co, Inc./RA Fischer Co. and affiliates any and all information pertaining to my insurance benefits and status of claims submitted by AR Hinkel Co, Inc./RA Fischer Co. and affiliates for services rendered. I further authorize AR Hinkel Co, Inc./RA Fischer Co. and affiliates to release to my insurance company(ies) any and all information pertaining to me for benefit determination.

I understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary.

If someone other than the patient is signing this authorization, please state the relationship with patient and the reason patient is unable to sign.

**Signature of Patient/Authorized Representative:** ________________________________

**Name of Authorized Representative:** ________________________________

**Relationship to Patient:** ________________________________________________
AUTHORIZATION FORM FOR THE R.A. FISCHER IONTOPHORESIS DEVICE

The _authorization can be written out on a regular prescription pad_. If not in the form of a prescription, the following authorization form is to be filled out by a licensed healthcare practitioner and _faxed to 818-775-2941 or emailed to rx@rafischer.com_

<table>
<thead>
<tr>
<th>PRACTITIONER'S INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner’s Name:</td>
</tr>
<tr>
<td>Clinic/Business Name:</td>
</tr>
<tr>
<td>Practitioner’s Address:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Fax Number:</td>
</tr>
<tr>
<td>Prescriber NPI:</td>
</tr>
</tbody>
</table>

| Patient’s Name:            |
| Patient’s Address:         |
| City:                      | State: | Zip code: |
| Phone Number:              |
| Patient Email Address:     |

Patients may then purchase the device through our website, and we will cross reference their order with their prescription. You can direct them to www.rafischer.com

If you have any questions, please call us at (800) 525-3467.

I am authorizing the use of the R.A. Fischer Iontophoresis device for _____________________________, for the treatment of Hyperhidrosis.

PATIENT’S NAME

______________________________
PHYSICIAN’S NAME PRINTED

Date ___/___/____

______________________________
PHYSICIAN’S SIGNATURE
Statement of Medical Necessity

DIAGNOSIS: Hyperhidrosis (abnormally high levels of excessive sweat) of palms of the hands and/or soles of the feet.

ANCILLARY MANIFESTATION: Extreme anxiety with condition; secondary medical condition (dermatitis, eczema, infection); occupational handicap, functional impairment.

AVAILABLE TREATMENT METHODS:
1) Iontophoresis. Iontophoresis makes use of an electronic medical device that generates a DC current for application to the affected areas (hands or feet). The patient uses a galvanic medical device to deliver current to the eccrine sweat ducts of the palms or soles. A series of treatments results in the development of hyperkeratotic plugs within the sweat ducts leading to poral closure. This results in a reduction in sweating. Since this reduction is temporary, retreatment at one to three-week intervals is necessary.
2) BOTOX® injections
3) Surgery (sympathectomy)

MEDICAL RECOMMENDATION: RA Fischer Company manufactures an iontropheotic device (MD-1A & MD-2) for self-treatment of the hands, feet, and/or underarms. Iontophoresis with the Fischer device is an economical solution to the medical problem of hyperhidrosis. More importantly, surgery has attendant and prohibitive side effects such as Horner’s syndrome, compensatory hyperhidrosis and gustatory sweating.

PROGNOSIS: Generally, the condition is chronic with a possible improvement later in life, and therefore the need for the device would be indefinite.

STATEMENT OF MEDICAL Necessity: I am writing on behalf of my patient, ______________________, to document the medical necessity of a Fischer Iontophoresis device for the treatment of hyperhidrosis. This letter provides information about the patient’s medical history and diagnosis and a statement summarizing my treatment rationale.

Hyperhidrosis, or excessive sweating, can have a devastating effect on a patient’s quality of life, causing physical discomfort, social embarrassment, and disruption of occupational and daily activities. This has certainly been true for the above patient who has been severely impacted by hyperhidrosis. The patient has also experienced the following (check all that apply):

☐ Tried and failed prescription strength antiperspirants (list name of prescription(s) below):

______________________________________________________

☐ Presence of medical complications or skin maceration with secondary infection (explain below):

______________________________________________________

☐ Significant functional impairment, as documented in the medical record (explain below):

______________________________________________________

In light of this clinical information, and this patient’s condition, a Fischer Iontophoresis device is medically necessary and warrants coverage. Please contact me if you require additional information.

__________________________
PHYSICIAN’S SIGNATURE

__________________________
PHYSICIAN’S NAME

__________________________
NPI

__________________________
DATE

Hyperhidrosis Preauthorization Request Form

Date: __________________________________________

Patient Name: ______________________________________

Patient DOB: ______________________________________

Insurance Member #: ________________________________

Clinic/Practice Name: __________________________________

Prescribing Doctor: __________________________________________

Prescriber NPI: __________________________________________

ICD-10 CODES

| PRIMARY FOCAL HYPERHIDROSIS | L74.51 |
| AXILLA | L74.510 |
| PALMS | L74.512 |
| SOLES | L74.513 |
| UNSPECIFIED | L74.519 |

SECONDARY FOCAL HYPERHIDROSIS | L74.52 |

What areas of the body require treatment?

☐ Axillary (Underarms)  ☐ Palmar (Hands)  ☐ Plantar (Feet)  ☐ Craniofacial

☐ Submammary  ☐ Other:________________________________________

Hyperhidrosis Disease Severity Scale:

☐ 1. Sweating is never noticeable & never interferes with daily activities

☐ 2. Sweating is tolerable and sometimes interferes with daily activities

☐ 3. Sweating is barely tolerable & frequently interferes with daily activities

☐ 4. Sweating is intolerable and always interferes with daily activities

Impairment of Daily Activities, & Impact on Quality of Life:

☐ Work & professional life  ☐ Sexual activities

☐ Meeting people  ☐ Sports

☐ Relationships with family & friends  ☐ Clothing/shoes

☐ Shaking hands  ☐ Emotional state

☐ Developing personal relationships  ☐ Education

☐ Other: __________________________________________________________
Previous Treatments:

☐ OTC Antiperspirants ☐ Rx Antiperspirants ☐ Iontophoresis (In-office CPT: 97033) ☐ BOTOX®
☐ Surgery (Local) ☐ Surgery (ETS) ☐ Oral Medications ☐ Psychiatric
☐ miraDry® ☐ None
☐ Other: ________________________________________________________________

Notes:
Please Attach Clinicals OR Chart Notes in Relation to Patient’s Hyperhidrosis