RA FISCHER
SWEAT LESS LIVE MORE
25 W. EASY STREET #301
SIMI VALLEY, CA 93065
(800) 525-3467
WWW.RAFISCHER.COM

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……Page 2
- ☐ 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" ……Pages 3
- ☐ Letter of Medical Necessity on Office Letter Head (template)……Page 4
- ☐ Completed Hyperhidrosis Preauthorization Request Form……Pages 5-6
- ☐ Pertinent Medical Chart History (please attach) ……Page 7

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.

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Patient Information Sheet

Patient Name: _____ **Date of Birth:** _____

CONTACT INFORMATION:

Address: _____

Email Address: _____ Patient Phone: _____

INSURANCE INFORMATION:

Plan Name: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder DOB: _____

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:_____

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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**

PRACTITIONER'S INFORMATION

Practitioner's Name:
Clinic/Business Name:
Practitioner's Address:
City: State: Zip code:
Phone Number:
Fax Number:
Prescriber NPI:

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

Patient Name: _____ **Patient DOB:** _____

Member ID: _____ **Date:** _____

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 iontophoretic 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 NECCESITY: 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

References: 1) Stolman LP. The treatment of palmar hyperhidrosis by iontophoresis. Arch Derm;123:893-896, 1987. 2) Stolman LP, Treatment of Hyperhidrosis: Dermatologic Clinics; Vol 16, Number 4,863-867,1998. 3)Stolman LP, Treatment of hyperhidrosis: J Drug Dermat; 2(5), 521-527, 2003.

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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: _____

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Previous Treatments:

☐ OTC Antiperspirants ☐ Rx Antiperspirants ☐ Iontophoresis (In-office CPT: 97033) ☐ BOTOX®

☐ Surgery (Local) ☐ Surgery (ETS) ☐ Oral Medications ☐ Psychiatric

☐ miraDry® ☐ None

☐ Other: _____

Notes:

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Please Attach Clinicals

OR

Chart Notes in Relation to Patient's Hyperhidrosis