Anodyne® Therapy Case Manager Order Form

Patient Information

Patient Name _____
Address _____
_____
Claim # _____
Preauthorization # _____

Policy Group Number _____
Patient ID _____
Phone (____)_____
Date of Birth_____Sex_____
Date of Injury (If Workers Comp) _____

Provider: Anodyne Therapy LLC 13570 Wright Circle, Tampa, FL 33626 Phone: 1-800-521-6664 FAX: 800-835-4581
Item Ordered: Anodyne Model 120 (HCPCS EO221) Service Start Date: _____
Supplier Charge: $2,995.00 purchase

Diagnoses - Please explain condition(s) or reason for use below

Provide Minimum of 2 ICD-9 Codes: _____, _____, _____, _____
Please attach copy of your physician order.

Insurance benefits will cover 100% of the above authorized amount: ____Yes ____No
I authorize payment to be made to Anodyne Therapy directly: ____ Yes ____No
Note: We only bill Workers Comp Carriers who authorize 100% payment

Physician Information

Physician's Name: _____ UPIN Number: _____
(Print)
Physician Address: _____City_____State _____Zip_____

Telephone Number: _____ FAX Number: _____

Case Manager Approval

_____ _____ _____ _____ _____
Payer Organization Claims Address City State Zip

_____ _____ _____ (___)_____ (___)_____
Name (Print) Signature Date Phone FAX

FAX physician order with this form to Anodyne Therapy at: 813-342-4415 or 800-835-4581
Orders will ship within 5 business days unless otherwise notified

Questions? Call Anodyne Therapy LLC • 1-800-521-6664