Insurance Form

Patient Name | D.O.B. _____ | _____

Patient Address _____

City, State, Zip _____

Patient Phone Number _____

Insurance Company _____

Patient I.D. Number _____

Prescribing Doctor Name _____

Practice I.D. Number _____

Description of UV Therapy Light:

This is to certify that I am currently treating the above named patient for Vitamin D Deficiency.

In this patient's case, the use of such a device should be regarded as both a medical necessity and a preferred method of treatment for this disorder. Because of necessary treatment features as to time of day and duration of use, the patient's possession of a home-use unit such as I have prescribed is a requirement for successful and practical therapy, and is, in my opinion, the most cost effective treatment alternative.

Vitamin D UV Light - CPT or HCPCS code: E0691

Code # and Diagnosis:

☐ ICD-10-CM E55.9 Vitamin D Deficiency

_____ _____

Prescribing Doctor Signature **Date**

KBD, Inc. DBA Sperti Sunlamp
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800-544-3757 - www.sperti.com