exogen®
ultrasound bone healing system

ULTRASOUND BONE HEALING SYSTEM ORDER FORM | HCPCS: E0760

All information must be supported by attached documentation.



Patient Name: _____
Date of Birth: _____ Sex (M/F): _____
Patient Phone: _____
Patient Address: _____
City/State/ZIP _____
Date of Follow-up Appointment: _____

Physician Name: _____ Office Address: _____
Office Contact: _____ City: _____ State: _____
Phone Number: _____ ZIP: _____ NPI (optional): _____

Primary Insurance: _____ Secondary Insurance: _____
Phone Number: _____ Phone Number: _____
Policy ID#: _____ Group#: _____ Policy ID#: _____ Group#: _____

Cause of Injury: ☐ Work Comp ☐ Auto ☐ Other: _____

FRACTURE INFORMATION:

Anatomic Location: _____ ☐ Displaced ☐ Nondisplaced Specific Location: ☐ Right ☐ Left
Fracture Gap: ☐ <1 cm ☐ ____mm Date of Injury: _____
Date of X-Rays Initial: _____ Current: _____ Date of Surgery: _____
Diagnosis Codes (ICD-10): _____

CO-MORBIDITIES: (check all that apply)

☐ Osteoporosis (M81.0) ☐ Long-term inhaled steroid use (Z79.51) ☐ Long-term systemic steroid use (Z79.52)
☐ Diabetes (E11.9) ☐ Vascular Disease (I99.9) ☐ Obesity (E66.9)
☐ Heart Disease (I25.10) ☐ NSAID non-steroidal use (Z79.1) ☐ Renal Disease (N28.9)
☐ Tobacco Use (F17.200) ☐ Other _____

We will communicate your patient's coverage to your patient and inform your clinical staff when your patient receives the EXOGEN device.

Did you attach all necessary documents?

☐ Signed prescription on physician personal Rx, including:
EXOGEN HCPCS: E0760, applicable ICD10 Code(s) & Fracture Gap Measurement
☐ Patient Facesheet/Demographics
☐ Copy of Insurance Information or ID Card
☐ Has the patient been asked for Secondary Insurance? ☐ Yes ☐ No
☐ Office/X-ray note(s) and Op report (if applicable) related to fracture
☐ Has the fracture location been marked/identified on patient? ☐ Yes ☐ No

EXOGEN Sales Representative: _____
Rep Number: _____
Phone: _____
Email: _____
Fax: _____

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