

Therapeutic Light Box - Durable Medical Equipment Insurance Form

Date: _____

Claimant: _____

SSN: _____

Insured: _____

Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Insurer: _____

Policy #: _____ Group #: _____

- _____ **Two in One Light Box with Indoor Sunshine & BlueStar Light – 10,000 Lux**
HCPC Code E-0203 Therapeutic Light Box. Min. 10,000 Lux Tabletop Model
- _____ **Mighty Mini Indoor Sunshine Light Box – 10,000 Lux**
HCPC Code E-0203 Therapeutic Light Box. Min. 10,000 Lux Tabletop Model
- _____ **Mighty Mini BlueStar Light Box – 10,000 Lux**
HCPC Code E-0203 Therapeutic Light Box. Min. 10,000 Lux Tabletop Model
- _____ **Indoor Sunshine Light Box 2500 lux**
CPT Code E-1399 Miscellaneous Durable Medical Equipment - Therapeutic Light Box

Diagnosis:

- | | |
|--|--|
| _____ DSM IV - 296.90

_____ DSM IV- 296.3
_____ DSM IV- 296.4
_____ DSM IV- 296.5
_____ DSM IV- 296.6
_____ DSM IV- 296.7
_____ DSM IV- 296.80
_____ DSM IV- 296.89
_____ DSM IV- 300.21
_____ DSM IV- 311.
_____ DSM IV- 314.00
_____ DSM IV- 314.01
_____ DSM IV- 327.31
_____ | Mood Disorder, NOS (not otherwise specified) with seasonal pattern specifier. Essential feature is onset and remission of major depressive episodes at characteristic times of the year. Used for Seasonal Affective Disorder.

Major Depression, Recurrent
Bipolar Disorder, Manic (Use Full Spectrum Light Box with manic individuals)
Bipolar Disorder, Depressed
Bipolar Disorder, Mixed (Use Full Spectrum Light Box with manic individuals)
Bipolar Affective Disorder Unspecified
Bipolar Disorder, NOS (not otherwise specified)
Bipolar II
Agoraphobia Used for housebound individuals.
Depressive Disorder, NOS (not otherwise specified)
ADD and ADHD, Predominantly inattentive without hyperactivity
ADD and ADHD, Combined with hyperactivity
Delayed Sleep Phase Syndrome |
|--|--|

Health Care Provider's Printed Name: _____ License #: _____

Address: _____ Office Phone: _____

City: _____ State: _____ ZIP: _____

Provider's Signature: _____

TO THE CLAIMANT: Please have your health care provider fill out the top portion first, then complete the bottom portion and mail to your insurer with a copy of the sales receipt/invoice.

I certify that the above is correct and true to the best of my knowledge.
I request that benefits be directly paid to myself _____ or the insured _____

Claimant Signature: _____ Date: _____

Signature of Insured (if other than Claimant): _____