



Great Lakes  
Home Healthcare Services

Prescription Request for Vacuum Erection Device (L7900)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

Physician Name \_\_\_\_\_ NPI \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ has been diagnosed with Organic Impotence (607.84).

The following condition(s) contributed to the diagnosis:

\_\_\_\_\_ 185 Carcinoma of Prostate \_\_\_\_\_ 952.9 Spinal Cord Injury

\_\_\_\_\_ 188.9 Carcinoma of the Bladder \_\_\_\_\_ 154.0 Colorectal Cancer

\_\_\_\_\_ 433.9 Peripheral Vascular Disease \_\_\_\_\_ 607.85 Peyronie's Disease

\_\_\_\_\_ 250.00 Type 2 Diabetes Mellitus \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ 250.01 Type 1 Diabetes Mellitus

\_\_\_\_\_ 401.9 Hypertension

Fax to: (814) 455-9440

Call (800) 772-7212 with any questions.