UPLIFT TECHNOLOGIES INC.
Bringing quality to life.

Can You Get Insurance Coverage For Your Day-Light ?

Most private insurance companies help cover the cost of a Light Therapy Lamp for those meeting the below diagnostic criteria. See reverse for a sample prescription letter that can be submitted to your insurance company, signed by either your Doctor or Therapist.

Remember that policies vary significantly among insurance companies. Your ability to get reimbursed, and the percentage of coverage for which you are eligible, depends not only on who your insurance company is, but also upon the specific terms of your individual policy. If in doubt, contact your insurance company for further information before purchasing a light therapy lamp.

Diagnostic Criteria for Seasonal Affective Disorder (SAD)

Your doctor may provide a SAD diagnosis if conditions A through F are met under Major Depressive Disorder, Section 296.3x. from ***Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition*** (DSM-IV), published by the American Psychiatric Ass., Washington D.C., 1994.

Major Depressive Disorder 296.3x

A. One of the following abnormal moods must be significantly interfering with your life:

1. Abnormal depressed mood most of the day, nearly every day, for at least 2 weeks.
2. Abnormal loss of all interest and pleasure most of the day, nearly every day, for at least 2 weeks.
3. If 18 or younger, abnormal irritable mood most of the day, nearly every day, for at least 2 weeks.

B. At least five of the following symptoms must have been present during the same 2-week depressed period.

1. Abnormal depressed mood (or irritable mood if a child or adolescent) [as defined in criterion A].
2. Abnormal loss of all interest and pleasure [as defined in criterion A2].
3. Appetite or weight disturbance, either:
   - Abnormal weight loss (when not dieting) or decrease in appetite.
   - Abnormal weight gain or increase in appetite.
4. Sleep disturbance, either abnormal insomnia or abnormal hypersomnia.
5. Activity disturbance, either abnormal agitation or slowing (observable by others).
6. Abnormal fatigue or loss of energy.
7. Abnormal self-reproach or inappropriate guilt.
8. Abnormal poor concentration or indecisiveness.
9. Abnormal morbid thoughts of death (not just fear of dying) or suicide.

C. The symptoms you experienced can not be due to a mood-incongruent psychosis (e.g., Schizophrenia, Delusional or Psychotic Disorders.)

D. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode (i.e., Bipolar Disorder).

E. The symptoms experienced cannot be due to physical illness, alcohol, medication, or street drug use.

F. The symptoms experienced cannot be due to normal bereavement.

Diagnostic Assessment For Insurance Coverage

Patient Name: _____

Insurance Company/Plan: _____

Patient I.D. Number: _____ **DOB**: _____

Assessment of Need for Phototherapy

This is to certify that I am currently treating the above named patient for recurrent major depressions (DSMIV-R-296.3) with a seasonal pattern.

This condition, known as Seasonal Affective Disorder (SAD), has been shown in many studies in the United States and Europe to respond to treatment with bright environmental light (phototherapy). Phototherapy is no longer considered experimental, but is a mainstream type of psychiatric treatment, described in the *Task Force Report of the American Psychiatric Association: Treatment of Psychiatric Disorders*, vol. 3, pages 1890-1896.

In the above patient's case, Seasonal Affective Disorder currently appears:

__ To be an isolated psychiatric disorder, or

__ Exists concomitantly with a previously-diagnosed psychiatric disorder of other origins (phototherapy being an addition to current other treatments).

In order to administer phototherapy adequately, a specialized lighting device, such as the one described on the attached invoice, is required. 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.

Code # and Diagnosis

DSM IV-296.3X - Major Depression, Recurrent (see reverse for evaluation criteria)

These procedures conform to April 1993 U.S. Public Health Service-Agency for Health Care Policy and research guidelines for management of this disorder.

Prescribing Doctor _____ **Date:** _____

Signature _____ **Practice ID No.** _____

Note: Please attach a prescription to this form.