UNITED PAIN DEVICES

Rx

PRESCRIPTION AND CERTIFICATE OF MEDICAL NECESSITY

Patient Name: _____ Date of Birth: _____

ICD 10 Diagnosis: _____

Patient Address: _____

Patient Phone: _____

☐ Surgical
Surgery date: _____

☐ Nonsurgical

☐ Left

☐ Right

☐ Cervical Collar
☐ Shoulder
☐ Back: Upper / Lower
☐ Arm / Elbow

☐ Wrist / Hand
☐ Hip
☐ Knee ☐ OA ☐ Post Op
☐ Foot / Ankle

☐ Cold Compression ☐ Cold Wrap Pro ☐ Brace ☐ E-Stim ☐ Cervical Traction ☐ Red Light Therapy

☐ Universal Wrap/Garment Electrode Replacement _____

------Please make sure the following are included------

- L.O.P
- MEDICAL NOTES
- LAW FIRM NAME.....
- CASE MANAGER EMAIL..
- DATE OF ACCIDENT.....
- STATE OF ACCIDENT.....

In my evaluation this patient has clinical findings that verify that the prescribed medical device is medically necessary to facilitate management of this patient's diagnosis according to the current accepted standards of practice.

I certify that the above described product is medically necessary and recommend that the patient use this device daily.

Physician's Name (PRINT): _____

Physician Signature: _____ Date: _____

Referring MD: _____

NPI: _____