

PRESCRIPTION AND CERTIFICATE OF MEDICAL NECESSITY

Patient Name: _____ Date of Birth: _____

ICD 10 Diagnosis: _____

Patient Address: _____

Patient Phone: _____

☐ Surgical Surgery date: _____	☐ Left	☐ Cervical Collar	☐ Wrist / Hand
☐ Nonsurgical	☐ Right	☐ Shoulder	☐ Hip
		☐ Back: Upper / Lower	☐ Knee ☐ OA ☐ Post Op
		☐ Arm / Elbow	☐ Foot / Ankle

☐ Cold Compression
 ☐ Brace
 ☐ Cervical Traction
 ☐ E-Stim/TENS/NMES
 ☐ Red Light Therapy

☐ Universal Wrap/Garment
 _____ Month
 ☐ 1 Year
 ☐ Lifetime

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

- **L.O.P**
- **MEDICAL NOTES**
- **LAW FIRM NAME.....**
- **STATE OF ACCIDENT.....**
- **DATE 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: _____

NPI: _____