LETTER OF MEDICAL NECESSITY

Patient Name:____

Diagnosis:____ ICD9 Code:________________

Type of Medical Equipment Prescribed:

- ☐ Cold Therapy Unit
- ☐ CPM ___ Knee ___ Shoulder
- ☐ Bracing Type:______________________
- ☐ Bone Stimulator: ___ Long Bone ____ Spine
- ☐ Pain Pump
- ☐ Additional Products:
- ☐ Digital Interferential Unit
- ☐ TENS Unit
- ☐ Traction Unit ___ Cervical ___ Lumbar
- ☐ EMS Unit
- ☐ High Volt Galvanic Unit
- ☐ TENS/IF Supplies

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Reason for Prescription and Treatment Goals:

- ☐ Increased Joint Range of Motion
- ☐ Increased Blood Circulation
- ☐ Reduction of Edema and Swelling
- ☐ Prevention of Retardation of Disuse Atrophy
- ☐ Adjunctive Treatment of the Management of Chronic Pain
- ☐ Relieve Symptomatic Pain
- ☐ Increasing or Maintaining Range of Motion
- ☐ Restore Functional Capacity to Allow the Return to Full Duty
- ☐ Increased Functional Mobility Capacity
- ☐ Relaxation of Muscle Spasms
- ☐ Functional Strength Deficits
- ☐ Symptomatic Relief of Pain and Management of Chronic Pain
- ☐ Management of Chronic Pain
- ☐ Cure & Relieve Patients Condition
- ☐ Muscle Reeducation
- ☐ Expedite / Advanced Expected Functional Capacity / Status to 80% / 90% of Normal
- ☐ Facilitate Independence in a Progressive Home Exercise Program with Functional Emphasis

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To Whom It May Concern:
I certify that the durable medical equipment that I have prescribed for use in the patients home, is medically necessary as part of my prescribed treatment plan for this patient. The prescribed equipment will aid in the symptomatic relief of pain, increase local blood flow, stimulate soft tissue healing, increase range of motion, aid in muscle reeducation and the relaxation of muscle spasms. The patients use of this equipment in their home will thus minimize the necessity for narcotic pain medication. In my opinion, a home unit as part of the patient's treatment protocol will facilitate his / her quicker return to functional restoration and participation in the activities of daily living. If I can provide further information, please do not hesitate to contact my office.

Sincerely:
Doctor's Signature:____
NPI #:______________________________
Print Doctor's Name:____
Address:____
City:___________________________________ State:________________ Zip:____________
Telephone:______________________________Fax:________________________________