

## LETTER OF MEDICAL NECESSITY

Patient Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Chronic / Intractable Pain:                      Mild                      Moderate                      Severe

### Body Region DME Prescribed For:

Lumbar     Cervical     Hand/Wrist     Knee     Ankle     Shoulder     Elbow     Other

### Equipment: *Please circle all that apply.*

TENS / EMS / IF    Leg Spacer    Theraball    Ultrasound    Other: \_\_\_\_\_

Brace    Wedge    Handisizer / Eggerciser / CT Stretch

Support Pillow    Cane / Crutches    Polar Care System

Posture Pump    Traction    Conductive Garment : *The conductive / form fitting garment is being prescribed because the patient can not manage without the use of this garment due to the large area needing to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes. The conductive / form fitting garment is being prescribed for use with the previously prescribed TENS / EMS / IF Unit.*

Polar Care System    Paraffin Bath

Analgesic Cream    Theraband

### Assessment / Objective Findings :

(+) Orthopedic Findings / Test(s)     ↓AROM / PROM's     Muscle Spasms / Guarding     (+) Radiographic Findings  
 ↓Disc Space(s) / Disc Wedging - C/T/L region     Chronic / Intractable Pain     Muscle Weakness (manual test)  
 ↓Sensory Responses -L/R - Upper Extremity / Lower Extremity     Other \_\_\_\_\_

Prognosis:    Excellent    Good    Fair    Guarded    Slow    Other: \_\_\_\_\_

### Previous Treatments

Therapeutic Modalities     Chiropractic Care     Non-prescription Pain Medication  
 Medical Care     Prescription Medication     Physical Therapy  
 Other \_\_\_\_\_

Length of Previous Treatments:     30 days     60 days     90 days     (+) 90 days

### Treatment Goals

Increase Ranges of Motion     Decrease Effusion / Inflammation     Decrease Muscle Spasms / Guarding  
 Increase Functional Capacity / Mobility     Relieve Symptomatic Pain / Manage Chronic Pain  
 Relieve Patient's Condition     Decrease Need for Meds -OTC /Rx     Other: \_\_\_\_\_

Prescribed Usage: \_\_\_\_\_ x Daily    \_\_\_\_\_ x Per Week    \_\_\_\_\_ PRN (As Needed)

*I certify that the above prescribed DME provided is medically necessary as a part of my treatment program for this patient. The prescribed DME is reasonable/necessary for the treatment of this patient's condition and progress. I authorize no substitution for this specific prescribed DME, as I have tried similar DME in the past with less desirable results, as they are of the highest quality & most effective DME for patient's area of concern.*

Doctor's Signature \_\_\_\_\_

Date: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

NPI# : \_\_\_\_\_

Address: \_\_\_\_\_

License # : \_\_\_\_\_

\_\_\_\_\_

Phone # : \_\_\_\_\_