Physician's Order, Prescription, and Certificate

Medical Necessity for DME

Claim Number:
Patient Name:
Provider Tax ID:
State Jurisdiction:
Provider:
State License No:

Date Of Injury:
Patient SS#
Patient DOB:
Date Reviewed:
ADJ#:

Secondary Provider:

BRACING

Upper: ☐ Cervical Collar Soft / Rigid
☐ Arm Sling Size: One size fits all
☐ Elbow Brace (Hinged) L/R: Size: XS S M L XL
☐ Wrist Hand Orthosis L/R Size:One size fits all
☐ Wrist Brace L / R Size: XS / One size fits all
☐ Thumb Spica L / R Size: One size fits all
☐ Industrial Back Support Size:One size fits all
Lower: ☐ Lumbar Spine Support (One size fits all)
☐ Knee Brace(Hinged)L /R Size: XS S M L XL XXL
☐ Knee Support Size: XS S M L XL XXL
☐ Ankle Brace L/R Size: One size fits all
☐ AFO Brace L/R Size: One size fits all
☐ Arch Supp/Foot Orthosis: Shoe Size_____

POST SURGICAL BRACES

☐ Shoulder Sling/Pillow Size: ____
☐ Shoulder Immobilizer Size: ____
☐ Elbow Hinged Brace Size: ____
☐ Industrial Back Support Size: ____
☐ Knee Brace (Hinged)L / R Size: ____
☐ Walker Boot Size: ____

MEDICAL NECESSITY

☐ Manage Pain ☐ Restrict ROM
☐ Limit ROM ☐ Stabilize Joint
☐ Protect Joint ☐ Protect Surgical Repair
☐ Increase ROM ☐ Other: _____
☐ Inflammation

☐ HOT & COLD UNIT WITH PUMP ☐ POST SURGICAL

☐ Motorized Hot & Cold Unit ☐ Purchase ☐ Rental 12 months **Reason:**
☐ Lumbar ☐ Knee ☐ Cervical / Shoulder ☐ PTP/ STP- Recommended on going care
☐ Wrist ☐ Hip ☐ Foot / Ankle ☐ Chronic Pain

MEDICAL NECESSITY

☐ Manage Pain ☐ Reduce Swelling
☐ Help in Rehab Process ☐ Post-Surgical Rehab
☐ Relax Muscle Spasms ☐ Other: _____

☐ ELECTROTHERAPY IF 4000 ☐ POST SURGICAL

☐ Prime Interferential Therapy (IF 4000)
(with supplies for period of medical necessity)
☐ Rental 12 months
☐ Purchase
Reason:
☐ PTP/ STP- Recommended on going care
☐ Chronic Pain

☐ Prime Dual Electrical Stimulator (TENS -EMS)
(with supplies for period of medical necessity)
Conductive Garment: ☐ Gloves ☐ Elbow Sleeves ☐ Knee Sleeves ☐ Socks

MEDICAL NECESSITY

☐ Manage / Reduce Pain ☐ Improve Circulation
☐ Increase ROM ☐ Expedite Recovery
☐ Relax Muscle Spasms ☐ Post OP Pain
☐ Reduce Swelling ☐ Reduce Edema
☐ Re-educate Muscle ☐ Prevent Atrophy
☐ Other: _____

TRANSDERMAL GEL / PATCHES

☐ Menthoderm Gel 240 Refills _____
☐ Terocin Patch (Menthol 4% Lidocaine 4%)

MEDICAL NECESSITY

☐ Manage / Reduce Pain

HOME EXERCISE KITS

Upper Body: ☐ Cervical / Neck ☐ Shoulder ☐ Hand / Wrist ☐ Elbow
Lower Body: ☐ Lumbar ☐ Knee ☐ Foot / Ankle

MEDICAL NECESSITY

☐ Increase Strength ☐ Manage / Reduce Pain
☐ Increase ROM ☐ Expedite Recovery
☐ Reduce Swelling

TRACTION UNITS

☐ Traction Unit
☐ Cervical Pump
☐ Other: _____

SPECIAL REQUEST

☐ Power Uplift Seat ☐ Shower Chair
☐ Three in one Commode
☐ Other_____

MEDICAL NECESSITY

☐ Manage Pain ☐ Reduce Swelling
☐ Help in Rehab Process ☐ Post Surgical Rehab
☐ Relax Muscle Spasms ☐ Other: _____

WALKING AIDS

☐ Cane Regular / Quad
☐ Crutches Size: S M L XL
☐ Front Wheeled Walker
☐ Walker with Brakes/Seat

PILLOWS / CUSHIONS

☐ Back Cushion ☐ Donut Cushion
☐ Cervical Pillow Full / Wrap Around
☐ Wedge Pillow

MEDICAL NECESSITY

☐ Manage Pain ☐ Reduce Swelling
☐ Help in Rehab Process ☐ Post Surgical Rehab
☐ Relax Muscle Spasms ☐ Other: _____

ESTIMATED LENGTH OF NEED FOR DME EQUIPMENT ☒ 3 TO 12 MONTHS

MEDICATION/DME MEDICAL NECESSITY VERIFICATION

Claim Number:
Patient Name:
Provider Tax ID:
State Jurisdiction:

Date Of Injury:
Patient SS#
Patient DOB:
Date Reviewed:
ADJ#:

Provider:_____
State License No:

Secondary Provider:

☒ **I HEREBY CONFIRM THAT I HAVE EVALUATED Mr./Mrs _____ ON _____. BASED ON MY EVALUATION AND THE AVAILABLE DIAGNOSTIC STUDIES, IT IS MY MEDICAL OPINION THAT THE PATIENT REQUIRES THE AFOREMENTIONED MEDICATION/DURABLE MEDICAL EQUIPMENT TO AID IN HIS/HER RECOVERY. THIS MEDICATION/DURABLE MEDICAL EQUIPMENT WILL BE USED TO ALLEVIATE PAIN AND DISCOMFORT, AND SPEED UP RECOVERY. THIS PRESRIPTION IS IN COMPLAINCE WITH THE CURRENT, WORKERS COMPENSATION GUIDELINES.**

☐ **MR./ MRS. _____ WAS REFERRED TO MY OFFICE FOR AN ORTHOPEDIC EVALUATION. AS THE SECONDARY TREATING PHYSICIAN, AND AFTER THOROUGH EVALUTAION, IT IS MY MEDICAL OPINION THAT THE PATIENT REQUIRES THE AFOREMENTIONED MEDICATION/DURABLE MEDICAL EQUIPMENT TO AID IN HIS/HER RECOVERY. THIS MEDICATION/DURABLE MEDICAL EQUIPMENT WILL BE USED ALLEVIATE PAIN AND DISCOMFORT, AND SPEED UP RECOVERY. THIS PRESCRIPTION IS IN COMPLIANCE WITH THE CURRENT WORKERS COMPENSATION GUIDELINES.**

U.S. Code § 1746

I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct.

PHYSICIAN'S INFORMATION

Deliver to: Physician's Office Patient's Home Address Dispense at Physician's office

Physician's Name _____ Date: _____

Physician's Signature: _____ Date: _____

Based on the patient's condition, symptoms and diagnosis, and in compliance with title 8, California code of regulations 4600(B),
I hereby notify that the prescribed Durable Medical Equipment is medically necessary to relieve patient's symptoms caused by his or her condition.