D.M.E. Prescription & Letter of Medical Necessity

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a medical equipment company
Phone (773) 666-5633 - Fax (888) 775 - 0887

PATIENT: _____ PHYSICIAN: _____

ACCOUNT: _____ FACILITY: _____

DIAGNOSIS- ICD10: _____ DOI: _____

Worker's Comp ( ) **Personal Injury / Auto Accident ( )**

GENERAL SUPPLIES

- ☐ TENS / EMS Unit (C1) ☐ Purchase
- ☐ Supplies of Electrodes and Lithium Batteries for Tens / EMS Unit (7)
- ☐ Knee Scooter
- ☐ Ultrasound Unit (OT1) ☐ Purchase
- ☐ Supplies of Conductive Gel for Ultrasound (9)
- ☐ Wheel Chair (ST2)
- ☐ Home Therapy Exercise Kit (HE1) Body Part _____
- ☐ Crutches (ST1)

BRACING / TRACTION UNIT

- ☐ Spine & Scapula Stabilizer (AM2) Size: S M L XL 2XL 3XL 4XL
- ☐ Cervical Traction Unit (R47)
- ☐ Lumbar Orthosis (O22) Size: S M L XL 2XL 3XL 4XL
- ☐ Knee Immobilizer (T14)
- ☐ Knee Orthosis (T3) Size: S M L XL 2XL 3XL 4XL
- ☐ Custom Ligament Orthosis - ACL (T11) Right Left - Medial Lateral
- ☐ Custom Unloader Orthosis (T7) Right Left - Medial Lateral

NON-SURGICAL / SURGICAL SUPPLIES

☐ Continuous Passive Motion / CPM (M1)	RENTAL LENGTH	☐ 4 Weeks	☐ 6 Weeks	☐ 8 Weeks
☐ Continuous Cold-Heat Therapy Unit (R113)	RENTAL LENGTH	☐ 4 Weeks	☐ 6 Weeks	☐ 8 Weeks
☐ Bone Growth Stimulator (DJ7)	RENTAL LENGTH	☐ 4 Weeks	☐ 6 Weeks	☐ 8 Weeks

BODY PART

Shoulder Knee Hand Elbow Ankle Cervical Thoracic Lumbar

Right Left

- ☐ Deep Vein Thrombosis (DVT) - Prophylaxis Unit (DVT1)
- ☐ Arm Sling W/Abduction Pillow (DJ5)

☐ Note: _____

_____

Based on my medical review and the patient's current condition, I certify, the device marked above is medically necessary. For the best possible outcome of the patient and to speed recovery, I recommend, the daily use of the device.

Physician Signature: _____ Date: _____