

Patient's Name _____ DOB _____

Diagnosis _____

Rx and LETTER OF MEDICAL NECESSITY

This is to certify that I have prescribed the following device from Ortho Plus, Inc. for hospital and/or home use. This modality is medically necessary for the patient's rehabilitation for the following reasons:

- Achieving normal function, maintain/increase range of motion
- Controlling pain, stiffness, and swelling
- Enhancing wound healing
- Controlling Adhesion formation
- Other: _____

Durable Medical Equipment:

- | | |
|--|---|
| <input type="checkbox"/> Knee CPM (E0935) | <input type="checkbox"/> Plexipulse/Talley Pneumatic compression unit (E0675) |
| <input type="checkbox"/> Shoulder CPM | <input type="checkbox"/> Sequential Compression Device (SCD E0675) |
| <input type="checkbox"/> Elbow CPM | <input type="checkbox"/> Compression Wraps (A9999/E1399) |
| <input type="checkbox"/> Hand/Wrist CPM | <input type="checkbox"/> Lymphedema pump (E0651) with pertaining sleeve(s) |
| <input type="checkbox"/> Ankle CPM | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> CPM Soft Goods (E1399/E0188) | |
| <input type="checkbox"/> Cryo pump with pad (E0218) | |
| <input type="checkbox"/> Non-spinal Bone Growth Stimulator (E0747) | |
| <input type="checkbox"/> Spinal Bone Growth Stimulator (E0748) | |
| <input type="checkbox"/> Bracing (off the shelf) _____ | |
| <input type="checkbox"/> Muscle Stim (E0745) | |
| <input type="checkbox"/> TENS unit (E0730) with electrodes | |

Date of Service: _____ Length of time needed _____

Physician Name _____ Phone _____

Physician's Signature Required _____

Date _____ **UPIN#** _____