PRESCRIPTION REQUEST

To: ______________________ **Re: Patient:** ______________________

From: ______________________ **Clinic:** ______________________

I'm requesting a prescription for home cervical traction to enhance the patient's rehabilitation and to:

☐ Manage Pain Symptoms ☐ Reduce Oral Pain Medication ☐ Reduce Disc and Nerve Pressure

FAX BACK TO: ______________________

PRESCRIPTION & MEDICAL NECESSITY

COMFORTRAC HOME CERVICAL TRACTION DEVICE

PATIENT NAME* ______________________ **DOB*** ______________________

PHONE* ______________________ **MOBILE/ALTERNATE** ______________________

I'm prescribing the Comfortrac Home Cervical Traction device because the patient requires greater than 20 pounds of traction for the treatment of:

ICD-10: ______________. I'm also recommending the Purchase of the cervical traction device for long-term use.

PROVIDER SIGNATURE* ______________________ **DATE*** ______________________

PRINTED NAME* ______________________ **NPI*** ______________________

ADDRESS ______________________

CITY ______________________ STATE ________ ZIP ________

PHONE ______________________ FAX ______________________

I CERTIFY THAT THE CERVICAL TRACTION I PRESCRIBED MEDICALLY NECESSARY FOR THIS PATIENT'S WELL-BEING; THIS IS NOT PRESCRIBED AS CONVENIENCE EQUIPMENT. IN MY PROFESSIONAL OPINION, THE EQUIPMENT IS BOTH REASONABLE AND NECESSARY IN REFERENCE TO THE ACCEPTED STANDARDS OF MEDICAL PRACTICE AND TREATMENT FOR THIS PATIENT'S CONDITION. SUBSTITUTION FOR THIS DEVICE IS *NOT ALLOWED WITHOUT MY WRITTEN APPROVAL.*

PLEASE FAX WITH PATIENT DEMOGRAPHICS

Rep Last, First Name