PRESCRIBER'S LETTER OF MEDICAL NECESSITY

Rx

Patient Name	

I am prescribing a Pulsed Electro-Magnetic Field (PEMF) Therapy device, called the OrthoCor Active System from OrthoCor Medical due to my patient's needs and diagnosis. I certify that the OrthoCor Active System device is medically indicated and in my opinion is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition.

I am writing on behalf of my patient that you approve coverage for the OrthoCor Active System device to provide Pulsed Electro-Magnetic Field Therapy (PEMF) for the reduction of pain and swelling. I consider this device medically necessary, and I am prescribing this device for the musculoskeletal injury treatment and/or post-operative treatment of my patient.

The OrthoCor Active System combines heat and PEMF therapies. The device is intended to treat post-surgical and acute injuries to reduce edema, swelling and pain. OrthoCor's PEMF Technology has been clinically proven to engage the body's natural anti-inflammatory processes. The anatomically-designed OrthoCor Active Systems has been engineered for all major body parts. The OrthoCor Active system is a Non-Narcotic, Non-Opiate, Non-Pharmacological pain relief alternative. PEMF has long been used to treat acute and chronic injury and assist in rehabilitation following surgery. This FDA Class III cleared device has been proven to restore blood flow, enhance revascularization of tissue, and provide pain relief while initiating the body's natural healing process. OrthoCor provides a Non-Narcotic, Non-Opiate pain, Non-Addictive pain relief alternative.

My post-operative and rehabilitative care plan calls for the use of the OrthoCor Active System to reduce pain and swelling, improve surgical outcomes, and return the patient to work promptly. Failure to control pain not only causes unnecessary suffering but can delay my patient's healing and recovery. Therefore, need for compliance with the required treatment is high. I certify that the above-described product is medically indicated and in my opinion is reasonable and necessary. Given the safety and effectiveness of this product, I prescribe and recommend that the patient use this device daily. Without use of this device, there is potential to cause unnecessary delay in the patient's recovery.

If you have any questions, please feel free to contact my office.

Prescriber Signature		**Date**
Prescriber Printed Name		**NPI**
Address		
City	State	Zip