DME Letter of Medical Necessity

Please fill in and Circle all that Apply and Attach Daily Notes

Patient Name:
Equipment: ☐ Tens/Supplies ☐ LSO ☐Cervical posture Pump **BRACES:** ☐Knee ☐R ☐L ☐Wrist ☐R ☐L ☐Ankle☐R ☐L ☐ Shoulder ☐R ☐L ☐Elbow ☐R ☐L **Size:** ☐Sm ☐ Med ☐ L ☐XL **OTHER:**
Diagnosis Codes:
Symptoms:
Chronic/Intractable Pain (Circle Pain) ☐**Mild** ☐**Moderate** ☐**Severe**
Body Region DME Prescribed For (Mark all that Apply) ☐Hand/Wrist ☐Knee ☐Ankle ☐Shoulder ☐Elbow ☐Back **OTHER:**
Length of Prescription (Circle One) ☐12 Months ☐24 Months ☐36 Months ☐99=Lifetime
Assessment Objective Findings (Mark all that apply) ☐Orthopedic Findings/Test(s) ☐AROM/PROM's ☐Muscle Spasms/Guarding ☐Radiographic Findings ☐Sensory Responses-L/R ☐Upper Extremity ☐Lower Extremity **OTHER**:
Assessment: ☐Excellent ☐Good ☐Fair ☐Guarded ☐Slow **OTHER:**
Previous Treatments (Mark all that apply) ☐Therapeutic Modalities ☐Chiropractic Care ☐Non-Prescriptive Pain Medication ☐Medical Care ☐Prescription Medication ☐Physical Therapy **OTHER:**
Length of Previous Treatments: ☐30days ☐60 days ☐90 days ☐ (+)90 days
Treatment Goals (Mark all that apply) ☐Increase Range of Motion ☐Decrease Effusion/Inflammation ☐Decrease Muscle Spasms/Guarding ☐Increase Functional Capacity/Mobility ☐Relieve Symptomatic Pain/Management Chronic Pain ☐Relieve Patient's Condition ☐Decrease Need for Meds-Otc/Rx **OTHER:**
Prescription Usage: xDaily xPer Week PRN(as Needed)

I certify that the above prescribed DME provided is medically necessary as a part of my treatment program for this patient. The prescribed DME is reasonable/necessary for the treatment of this patient's condition and progress. I authorize no substation for this specific prescribed DME, as I have tried similar DME in the past with less desirable results, as they are of the highest quality & most effective DME for the patient's area of concern.

Doctor's Signature_____ Date: _____

Doctors: _____ NPI#_____

Address:_____ Phone: _____ Fax:_____