Fax: (844) 760-0495

InfraRed Heating Pad Unit Rx / LMN

InfraRx.com

Patients Name_____DOB:_____

Insurance Carrier: _____ Employer: _____ Claim #: _____

DOI (WC/NF): _____ Type: [ ] *Comp* [ ] *Auto* Dx_____ Attorney: _____

***InfraRx*™ Infrared Heating Pad Unit**

☐ Shoulder ☐ Back ☐ Ankle/Foot ☐ Hip ☐ Neck ☐ Knee ☐ Wrist/Hand ☐ Thigh ☐ Elbow ☐ Calf

Side: [ ] RIGHT [ ] LEFT

I certify that the Far-Infrared Heating Pad ("FIR Heat Pad") that I have prescribed for use in the patient's home is medically necessary as part of my prescribed treatment plan for the patient. Clinical trials have proven the efficacy of infrared technology for various types of pain that is often left unchanged by traditional pain management strategies. For instance, a double blind, placebo-controlled study published in 2006 concluded that "The FIR Heat Pad has clearly demonstrated that it is easy to use, safe and effective, and reduced chronic back pain by 50% over six weeks".[1]

Infrared products are unique in that the heat doesn't burn or dehydrate and penetrates approximately 2.5 inches beneath the surface of the skin, targeting pain and inflammation where it originates. This offers a therapeutic advantage over and above traditional heat that is only capable of shallow penetration. Infrared heat acts to increase the flexibility of collagen tissue, reduce inflammation, decrease joint stiffness, relieve muscle spasms, reduce pain, increase range of motion and promote healing in the affected area.

Use of the FIR Heat Pad ***should minimize the necessity for narcotic pain medication***.

In my opinion, a home FIR Heat Pad as part of the patient's treatment protocol will facilitate the patient's quicker return to functional restoration and participation in the active duties of daily living.

Since I am acquainted with the efficacy of the FIR Heat Pad, I would like it to be considered as medically necessary as my prescribed treatment plan to have my patient return to normal functionality. This is NOT prescribed as convenience equipment. Substitution for this device is NOT ALLOWED without my written approval.

If I can provide further information, please do not hesitate to contact my office.

PROVIDER NAME PRINTED: _____

PROVIDER SIGNATURE: _____ **DATE:** _____

My Signature and date below authorizes each of the following:

1. Direct billing to appropriate healthcare insurance policies.
2. Alikai Health to obtain medical or other information necessary in order to process claim(s), including determining eligibility and seeking reimbursement for medical equipment or supplies provided.
3. Alikai Health to contact me by telephone or mail regarding my medical equipment or supplies.

PATIENT SIGNATURE: _____ **DATE:** _____

(Patient signature indicates understanding of the return policy and acknowledges receipt of the above product)

Shipped with Tracking Confirmation #: _____ **Date:** _____

[1] GD Gale, PJ Rothbart, Y Li. Infrared therapy for chronic low back pain: A randomized, controlled trial. Pain Res Manage 2006;11(3):193-196.