Rehab Services, LLC
100 Cathedral Street, Suite 2
Annapolis, MD 21401

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NPI: 1487696852

Therm-X
Physician Order, Prescription and Certificate of Medical Necessity

Patient Name: _____ Date of Order: _____

Patient Phone Number: _____ Date of Birth: _____

Date of Surgery: _____ Date of Injury: _____

ICD-10 Code and/or Description: _____

Side: ☐ Left ☐ Right

Medical Device ordered: Therm-X Cold, Heat, Contrast and Compression Unit with Wrap

Initial Settings / Goal: _____

Initial Duration of Medical Necessity: ☐_____Weeks ☐ Lifetime (99) ☐ Other _____

Order Information

Qty	Description	Mfr #
_____	Therm-X AT	TX0001
_____	Therm-X Shoulder Garment	TX0101
_____	Therm-X Knee Garment	TX0102
_____	Therm-X Elbow Garment	TX0103
_____	Therm-X Ankle Garment	TX0104
_____	Therm-X Back Garment	TX0105
_____	Therm-X Hip Garment	TX0108
_____	Therm-X Split Umbilical Hose	TX0208
_____	Therm-X Travel Case	TX0202
_____	Therm-X Coolant (1 Quart)	TX0206

Other: _____

By signing below, I am prescribing the Therm-X Cold, Heat, Contrast and Compression Therapy System due to my patient's needs and diagnosis. I certify that the Therm-X Unit and Wrap is medically indicated and in my opinion is reasonable and necessary with reference to the accepted standards of medical practice and treatment of the patient's condition.

Physicians Signature: _____ Date: _____

Physicians Printed Name:_____ NPI :_____

Notes: _____

Please include Patient Demographic Sheet and fax to Rehab Services, LLC at 800.486.5633 or email shawn@rsmedco.com