Mid State Medical of PA LLC

717-881-8900

Prescription & Letter of Medical Necessity

Patient Name	DOB	Date of Injury	Date of Surgery

Patient Phone Number	PRIMARY ICD-10 CODE	SECONDARY ICD-10 CODE

ELECTRICAL STIMULATION

LENGTH OF NEED: ○ PURCHASE ○ RENTAL #_____Months

- ☐ INTERFERENTIAL COMBINATION STIMULATOR (E1399) WITH SUPPLIES
- ☐ TENS UNIT (E0730) WITH SUPPLIES
- ☐ NMES UNIT (E0745) WITH SUPPLIES
- ☐ CONDUCTIVE GARMENT (Purchase Only) **CIRCLE** Low Back Glove Sock Other _____

CERVICAL TRACTION

LENGTH OF NEED: ○ PURCHASE ○ RENTAL # _____Months

- ☐ HOME CERVICAL PNEUMATIC TRACTION UNIT (E0849)

1.	Patient has a musculoskeletal or neurological impairment requiring the use of this equipment	○ YES	○ NO
2.	Appropriate use has been demonstrated and the device was tolerated by the patient	○ YES	○ NO
3.	Physician has ordered more than 20lbs of force	○ YES	○ NO
4.	Patient has a diagnosis of TMJ dysfunction and has received treatment for this condition	○ YES	○ NO
5.	Patient has a distortion of the lower jaw or neck anatomy preventing use of a chin halter	○ YES	○ NO

SPINAL ORTHOSIS

LENGTH OF NEED: ○ PURCHASE ○ RENTAL # _____Months

☐ ASPEN Cervical Therapy Collar (L0180) ☐ ASPEN Horizon (L0648/L0631) T9-S1 ☐ ASPEN Horizon (L0642/L0627) L1-L5 ☐ Aspen Vista (639) LSO 4 Panel

☐ ASPEN Horizon (L0457/L0456) TLSO ☐ ASPEN PEAK SCOLIOSIS BRACE (L1005) ☐ ASPEN Horizon (L0650/L0637) T9-S1 Lateral Support

- ☐ reduce pain by restricting mobility of the trunk
- ☐ facilitate healing following an injury to the spine or related soft tissue
- ☐ facilitate healing following a surgical procedure on the spine or related soft tissue
- ☐ otherwise support weak spinal muscles and / or deformed spine

PROVIDER SIGNATURE		DATE

PRINTED NAME	NPI	PHONE

I certify that the equipment and supplies I prescribed are medically necessary for the 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 PATIENT DEMOGRAPHICS AND INSURANCE TO: 888-255-0868