DR NAME, MD
NPI #:
ADDRESS
CITY, ST. ZIP
Phone:
Fax:

PLEASE COMPLETE AND FAX BACK
OR MAIL TO
CAPITAL MEDICAL CORPORATION
PO BOX 15013
TALLAHASSEE, FL 32317-5013
Phone: (850) 386-1978
Fax: (850) 386-3151

PRESCRIPTION AND LETTER OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT AND/OR ORTHOTICS

Patient:_____ **DOB:**_____

Address:_____

Insurance #:_____

Diagnosis:_____

ICD-9 CODE(S):_____ _____ _____ _____

DO Surgery:_____

TYPE OF EQUIPMENT PRESCRIBED:

- ❑ KNEE CPM
- ❑ ELBOW CPM
- ❑ WRIST/HAND CPM
- ❑ WRIST CPM
- ❑ SHOULDER CPM
- ❑ STATIC PROGRESSIVE SPLINT ORTHOSIS
- ❑ COLD THERAPY
- ❑ HOT/COLD THERAPY
- ❑ COMMODE
- ❑ WALKER
- ❑ CANE
- ❑ OTHER_____

THIS EQUIPMENT IS BEING PRESCRIBED AND IS MEDICALLY NECESSARY FOR THE FOLLOWING REASON(S);

- ❑ TO MAINTAIN RANGE OF MOTION
- ❑ TO REDUCE POST-OPERATIVE PAIN AND SWELLING
- ❑ TO PREVENT THE FORMATION OF INTRA-ARTICULAR-ADHESIONS AND EXTRA-ARTICULAR CONTRACTURES
- ❑ TO INCREASE FLEXION OR EXTENSION RANGE OF MOTION
- ❑ CONTRACTURE MANAGEMENT
- ❑ OTHER:_____

PROGNOSIS: _____ EXCELLENT _____ GOOD _____ FAIR _____ POOR (CHECK ONE)

EXPECTED DURATION OF TREATMENT: _____

I certify that I am actively treating this patient. This equipment is part of my recommended treatment and is "reasonable and medically necessary". The above information is true and accurate, to the best of my knowledge.

PHYSICIAN'S SIGNATURE: _____DATE: _____