Pain Rehab Products, Inc.

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Prescription & Certificate of Medically Necessity

Patient's Name: _____ *Patient's DOB:* _____/_____/_____

Patient's Address: _____

Diagnosis Codes ICD 10 Primary: _____ Secondary: _____

Night Splint

☐ L4396 Night Splint

Walker Boot

☐ L4361 Walker Boot - Pneumatic

☐ L4387 Walker Boot - Non-Pneumatic

☐ Right ☐ Left

Duration: Patient has had this condition for ____ Months ____ Years

Length of Need: **Months** _____ (99 = lifetime)

Physician Information

I certify that the equipment and supplies I prescribed are medically necessary for this patient's well being. 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. It is NOT prescribed as convenience equipment. Substitution for this device is NOT ALLOWED without my written approval.

Physician's Signature: _____ Date: _____/_____/_____
(Stamped Signatures are not acceptable)

Printed Physicians Name: _____ NPI #: _____

Physician's Address: _____

Required for ALL Medicare Patients:
Chart Notes & Rx must be submitted together, Include chart notes supporting Medical Necessity (clinical documentation must support the continued need, use and benefit the device provides)

Along with this RX, please fax the patient's medical records, insurance card and demographics to (314) 832-1430. Pain Rehab Products, Inc. will provide the insurance pre-certification, patient fitting and follow-up.