



Pain Rehab Products, Inc.

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www.painrehabproducts.com

Prescription & Certificate of Medical Necessity

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

Patient's Address: _____

Diagnosis Codes ICD-10 Primary: _____ Secondary: _____

Orthopedic Bracing and DME

Brand/Manufacturer: _____

Model: _____

Item #: _____

HCPCS Code: _____

Left

Right

N/A

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.