

## Patient Information

Personal Information			
First Name	EMILY	Middle Name	-
Last Name	EDWARDS	D.O.B	01/24/2003
Gender	Female	Address	423 SOUTH FULLTON AVE APT3
City	MOUNT VERNON	State	NEW YORK
Cell Phone #	347-206-6391	Home Phone	718-881-5845
Work	-	Zip	10553
Email	-	Extn.	-
Attorney	DOMINICK LAVELLE	Case Type	No-Fault
Attorney Address	100 HERRICKS ROAD SUITE 201	Attorney Phone	800-745-4878
Case Status	OPEN	SSN	-

Insurance Information			
Policy Holder	-	Name	LIBERTY MUTUAL INS.
Address	P.O. Box# 1052	City	Montgomeryville
State	PENNSYLVANIA	Zip	18936-1052
Phone	800 245-1700	Fax	-
Contact Person	-	Claim File #	034381648
Policy #	AOS228001979405		

Accident Information			
Accident Date	09/14/2016	Plate Number	-
Report Number	-	Address	-
City	-	State	-
Hospital Name	-	Hospital Address	-
Date of Admission	-	Additional Patient	-
Describe Injury	-	Patient Type	Passenger

Employer Information			
Name	-	Address	-
City	-	State	-
Zip	-	Phone	-
Date of First Treatment	-	Chart #	-

Adjuster Information			
Name	-	Phone	-
Extension	-	Fax	-
Email	-		

# PRESCRIPTION/ LETTER OF MEDICAL NECESSITY

## PATIENT INFO:

PATIENT NAME

SURGERY DATE

DIAGNOSIS CODES

## EQUIPMENT PRESCRIBED:

### CONTINUOUS PASSIVE MOTION DEVICE (CPM)

#### PART OF THE BODY:

☐ KNEE ☐ RIGHT ☐ LEFT

☒ SHOULDER ☐ RIGHT ☒ LEFT

☐ OTHER

☐ ANKLE ☐ RIGHT ☐ LEFT

☐ WRIST ☐ RIGHT ☐ LEFT

DURATION

SPECIAL INSTRUCTIONS

## MEDICAL NECESSITY REASONING:

I am prescribing CPM (Continuous Passive Motion) that will help my patient during the post-operative recovery by increasing range of motion, preventing the development of motion-limiting adhesions, decreasing soft tissue stiffness and stimulating healing of joint surfaces and soft tissues. Moreover, the prescribed CPM Device will involve movement of the joints without active contraction of muscle groups and without patient effort, in view of the fact that, active movement that might destabilize the recovery and, also cause a painful process. Inasmuch, using CPM Device, my patient will experience less pain, recover faster, and, consequently there will be less pain medication and physical therapy required.

Physician Signature: \_\_\_\_\_

Physician Name: Dr. Anjani Sinha

NPI Number: 1932233715

License Number: \_\_\_\_\_

Address: 164-10 Northern Blvd., Ste 204, Flushing NY 11358

TEL: 718-886-2011

# PRESCRIPTION/ LETTER OF MEDICAL NECESSITY

## PATIENT INFO:

PATIENT NAME

SURGERY DATE

DIAGNOSIS CODES

## EQUIPMENT PRESCRIBED:

### COLD THERAPY CIRCULATING PUMP/GR

#### PART OF THE BODY:

☐ KNEE ☐ RIGHT ☐ LEFT

ANKLE ☐

☐ RIGHT ☐ LEFT

☒ SHOULDER ☐ RIGHT ☒ LEFT

WRIST ☐

☐ RIGHT ☐ LEFT

☐ OTHER

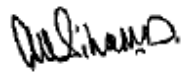
DURATION

SPECIAL INSTRUCTIONS

## MEDICAL NECESSITY REASONING:

I am prescribing Cold Therapy Circulating Pump/GR, as this device is medically necessary and reasonable in reference to my patient's post-operative recovery. This pneumatic cold compression therapy system will provide my patient adjustable cold and intermittent compression. Insofar as it is a proven and effective technique in post-operative recovery. Respectively, the Cold Therapy Unit will productively reduce recovery time as well as reducing swelling, edema and pain. By delivering comprehensive, flexible, and proven treatment of swelling, edema, pain or/and other post-surgical or injury conditions, I consider that my patient's rehabilitation process will be highly alleviated.

Physician Signature:



Physician Name:

Dr. Anjani Sinha

NPI Number:

1932233715

License Number:

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