

PRESCRIPTION/ LETTER OF MEDICAL NECESSITY

PATIENT INFO:

PATIENT NAME _____

SURGERY DATE _____

DIAGNOSIS CODES _____

EQUIPMENT PRESCRIBED:

DVT DEVICE

DURATION PRESCRIBED:

☐

2 WEEKS

☐

4 WEEKS

☐

6 WEEKS

PART OF THE BODY:

☐

KNEE

☐

RIGHT

☐

LEFT

☐

OTHER _____

SPECIAL INSTRUCTIONS _____

MEDICAL NECESSITY REASONING:

I am prescribing DVT Device for my patient in order to avoid the Deep Venous Thrombosis risk factor during recovery. As DVT Device is clinically proven to reduce the risks associated with deep vein thrombosis and pulmonary embolism following surgery. It will accelerate venous velocity also will prevent complications as Chronic Venous Insufficiency which arises when DVT damages the veins in the legs, preventing the proper flow of blood to your extremities and causing chronic pain, leg ulcers, and difficulty walking.

I have assessed this patient's risk of DVT due to the type of surgery, the patient's medical history, and other documented factors that increase the risk of DVT. My assessment indicates the use of mechanical thromboprophylaxis by pneumatic compression device and segmental gradient pressure pneumatic appliances. In my opinion this is medically necessary and reasonable in accordance with accepted standards of medical practice and appropriate treatment of this patient.

Physician Signature: _____



Physician Name: _____

Dr. Anjani Sinha

NPI Number: _____

1932233715

License Number: _____

Address: _____

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