

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

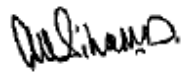
DURATION

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:

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