

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



ANKLE

☐ RIGHT

☐ LEFT



SHOULDER



RIGHT

☐ LEFT



WRIST

☐ RIGHT

☐ LEFT



OTHER

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

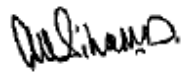
DURATION

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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License Number:

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718-886-2011

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: _____

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

TEL: _____

718-886-2011