Printed on :

Patient Information

Personal Information

First Name		**Middle Name**	
Last Name		**D.O.B**	
Gender		**Address**	
City		**State**	
Cell Phone #		**Home Phone**	
Work		**Zip**	
Email		**Extn.**	
Attorney		**Case Type**	
Attorney Address		**Attorney Phone**	
Case Status		**SSN**	

Insurance Information

Policy Holder		**Name**	
Address		**City**	
State		**Zip**	
Phone		**Fax**	
Contact Person		**Claim File #**	
Policy #			

Accident Information

Accident Date		**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission		**Additional Patient**	
Describe Injury		**Patient Type**	

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

EQUIPENT PRESCRIBED:

CONTINUOUS PASSIVE MOTION DEVICE (CPM)

PART OF THE BODY:

- [x] **KNEE** ☒ RIGHT ☐ LEFT
- [ ] **SHOULDER** ☐ RIGHT ☐ LEFT
- [ ] **ANKLE** ☐ RIGHT ☐ LEFT
- [ ] **WRIST** ☐ RIGHT ☐ LEFT

OTHER _____

2-4 Weeks

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

EQUIPENT PRESCRIBED:

COLD THERAPY CIRCULATING PUMP/GR

PART OF THE BODY:

☒ **KNEE** ☒ RIGHT ☐ LEFT **ANKLE** ☐ ☐ RIGHT ☐ LEFT

☐ **SHOULDER** ☐ RIGHT ☐ LEFT **WRIST** ☐ ☐ RIGHT ☐ LEFT

OTHER _____

2-4 Weeks

_____

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: _____

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

EQUIPENT 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