



Bone Growth Stimulator Prescription  
and Medical Necessity Form

Patient Name	Marissa K Donovan				Home #	614-534-8921					
Address	4182 Evergreen Meadows				Work #						
City	Westerville	State	OH	Zip	43082	SSN	421-58-9320	Birth date	14 Aug 1974	Sex	F
Physician Name	Dr. Samantha Chen				Office Contact			Phone #	614-322-4801		
Practice Name	Mid-Ohio Spine Group				NPI #	1285769043		Fax #	614-322-4802		
Address	75 Polaris Pkwy				City	Westerville		State	OH	zip	43082

### INSURANCE INFORMATION

<b>Primary Insurance</b>					<b>Secondary Insurance</b>						
<input type="checkbox"/> HMO <input checked="" type="checkbox"/> PPO <input type="checkbox"/> IND <input type="checkbox"/> POS <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Auto Liability <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____					<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> IND <input type="checkbox"/> POS <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Auto Liability <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____						
Name of Insured	Marissa Donovan		Birth date	8/14/1974		Name of Insured	Marissa Donovan		Birth date		
SSN	421-58-9320		Relation to Patient	Self		SSN	421-58-9320		Relation to Patient	Self	
Insurance Carrier	Blue Cross 880		Address			Address			Address		
City	State	Zip	City	State	Zip	City	State	Zip	City	State	Zip
Policy / Claim No.	BCP4281736		Subscriber / ID No.	1 Group # 20519		Policy / Claim No.	5MDX882041		Subscriber / ID No.		
Insurance Co. Phone #			Contact			Insurance Co. Phone #			Contact		
Employer of insured	Westerville City Schools		Phone #			Phone #			Contact		

### MEDICAL SUMMARY (To be completed by the prescribing individual only)

**Primary Diagnosis**

- Degenerative Disc Disease
  - Internal Disk Disruption
  - Herniated Nucleus Pulposus
  - Lumbar Instability
  - Low Back Pain
  - Other \_\_\_\_\_
- Scoliosis       Spondylolisthesis / Grade \_\_\_\_\_
- Radiculopathy - lumbar region

ICD9 Code(s) M51.16 M51.36

**Planned Procedure:**

Date 11/17/2024  
Fusion Surgery 11/25

Other \_\_\_\_\_

**PLEASE READ AND SIGN BELOW:** I understand the Food and Drug Administration has approved the SpinaLogic Bone Growth Stimulator (SpinaLogic) to use as an adjunct treatment to primary lumbar fusion surgery for one or two levels. I acknowledge that DJO, LLC, has not promoted SpinaLogic to me for any other use or otherwise encouraged me to order it for any other use. I specifically desire to order the SpinaLogic, which is only available directly from DJO, LLC, so that I may treat the patient in question according to my informed medical judgement. By my signature below, I am prescribing the bone growth stimulator device listed above. In my judgement, the above-prescribed item is medically indicated and necessary, and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

Prescriber's Signature

Daniel Miller  
Daniel Miller

REPRESENTATIVE NAME / TITLE (PRINT)

Date

11/02/2024

SIGNATURE

DJO Clinical Rep

REPORTING CLINIC # (REQUIRED)  
OH-32415

**DISPENSE AS WRITTEN**

(no substitutions without authorization from prescribing individual)  
Please retain a copy for your records

DATE