BILLY H. FORD, MD, PC

bhfordmdpc@gmail.com

Patient: txtName|patientfullname
Provider: Billy Ford MD

DOB: txtDOB|DOB
Date: txtDate|ToDay

***DME Letter of Medical Necessity:**

Patient Information:

txtName2|patientfullname

txtAddress|fullAddress

Date of Birth: txtDOB2|DOB

Insurance: txtInsCo|InsCo
Policy #: txtCliamNo|ClaimOrPolicy_No

Medical Necessity Note:

I am requesting that a segmental cold compression therapy device is authorized for at-home utilization as the patient is experiencing substantial pain and inflammation. Cold therapy will reduce the patient's pain/reduce the need for pain medication while the simultaneous segmental compression will control and reduce inflammation. I would like for the patient to receive these items within the next week where they will then be educated, and can begin treatment to mitigate symptoms worsening. I deem this medically necessary. Thank you.

RX for: Segmental Compression / Cold Pack Therapy

Billy Ford, MD