Pro Med, Inc.
7125 Marvin D. Love Frwy. #360
Dallas TX 75237

PHYSICIAN DETAIL WRITTEN ORDER (RX) AND LETTER OF MEDICAL NECESSITY

Fax 214-242-8079
PHONE 972-773-9308
Email: dme@promedortho.com

Patient Information	Insurance Information
Name:	Ins. Company:
Address:	Ins. Phone:
	Policy ID#:
Phone:	Group #:
SS #:	Adj. Name: PH:
Date Of Birth: Male / Female	CL #: DOI:
Prescribing Physician:	ICD10/Diagnosis (REQUIRED):
Physician Phone #: Fax #: NPI #:	

Rx: Doctor, please indicate all services you would like Pro Med Inc. to provide to your patient: Please include any special instructions necessary to ensure accurate and specific treatment.

AMBULATORY

- □ Single Point Cane/4 Point
- □ Crutches
- □ Wheelchair □ Light Weight □ Ultra Light Weight □ Custom
- □ Walker/Rollator Walker/Knee Walker
- □ Raised Toilet Seat
- □ Bed Side Commode

EXTREMITIES

- □ Hinged Elbow Brace
- □ Wrist Cock Up □ Thumb Spica
- □ Breg Shortrunner w/ Hinges
- □ Functional ACL Brace
- □ OA Knee Brace □ L1845 Custom OA □ L1846
- □ Soft OA Brace Undersleeve □ L2397
- □ Knee Immobilizer
- □ Pneumatic Walking Boot
- □ Fracture Boot
- □ Ankle Brace
- □ Breg Ultra Ankle CTS
- □ Ankle Stir-Up
- □ Shoulder Abduction Sling
- □ Shoulder Immobilizer
- □ Plantar Fasciitis Night Splint
- □ AFO-Standard-Dynamic
- □ Orthopedic Shoes
- □ Orthotics

Home Therapy

- □ Moist/Dry Heat Pad
- □ Hand Therapy
- □ Paraffin Bath
- □ Paraffin Wax
- □ Inversion Table
- □ Bed Wedge
- □ Shoulder Therapy Kit
- □ Active Cold Therapy Systems
- □ Ergonomic Chair

CERVICAL AND LUMBAR

- □ Cervical Collar-Soft/Cervical Collar Semi Rigid-Aspen Therapy Collar
- □ Lumbar Back Brace (LSO)____________________ □ L0642 / L0627 SIZED
- □ TLSO □ L0642 / L0627 ADJUSTABLE
- □ Lumbar Pillow/Cervical Pillow □ L0648 / L0631
- □ Cervical Traction □ Lumbar Traction □ L0650 / L0637

STIM/EMS

- □ NMES/EMS/TENS Unit (Serial #) ____________________
- □ STIM Garment
- □ Conductive Spray 8 OZ 12OZ
- □ Batteries 4 6 8 10
- □ Electrodes 4PKS PER MTH 1MTH 3MTHS 6MTHS 12MTHS 99MTHS

Pain Management/Anti Inflammatory

- □ sam® Sport
- □ sam® Sport Patches: 2 Months
- □ sam® Sport Patches: 1 Year
- □ **Lantz Static/Dynamic Brace**
- □ **Brace Type** ______________
- □ **Length of need** ______________

Miscellaneous/Post Op

- □ Hot/Cold Therapy System
- □ DVT Compression System Take Home
- □ Bone Growth Stim □ Spinal □ Long Bone
- □ Post Op T-Scope Knee Brace Post Op T-Scope Elbow Brace
- □ CPM □ Knee □ Hand
- □ Lymphedema Compression Unit
- □ Lymphedema Garment
- □ Hip Abd. Brace/Philippon Hip
- □ Abdominal Binder

PLACE LABEL HERE

□ MISC____
Item Purchase/Rental Serial/Item #

Physician Signature:______________________________ Date:______________

I have prescribed the above durable medical equipment for treatment of the referenced patient. It is both reasonable and medically necessary effectuate a maximum and expedient recovery. CHECK ALL THAT APPLY. It is prescribed to

- □ Reduce Pain
- □ Reduce Muscle Spasm
- □ Post- Operative/Post Procedural Pain Control and Edema
- □ Reduce Reliance on Narcotics/Analgesics
- □ Reduce Edema/Swelling
- □ Increase Range of Motion (ROM)
- □ Post-Operative/Surgical Procedure
- □ Length of need ______________
- □ Other (specify below):

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To be signed and completed by patient upon receipt of product(s):

Dear Patient: PLEASE READ THIS STATEMENT AND SIGN BELOW

Pro Med Inc. is not financially affiliated with the medical group or physician. Your physician must prescribe all services and/or products provided by Pro Med Inc. I here-by authorize Pro Med Inc. to furnish this service/product and to provide my insurance company with any information requested for payment. I also instruct my insurance company to pay Pro Med Inc. directly for these service/products. I understand that all costs for service/products not paid for by my insurance company for any reason will become my personal financial responsibility. Assignment of benefits does not guarantee that my insurance company will pay for these service/products. I have received the above referenced product/services from Pro Med Inc., and have been instructed in the care and use of the product. I understand that all medical devices are not returnable for any reason other than material defect. MEDICARE AND OTHER INSURANCE COMPANIES will only pay for services/products that they determine to be reasonable and necessary under section 1862(a)(1) of the Medicare regulations. It Medicare or other insurance company determines that the product/service, although otherwise a covered product/service, is not reasonable or necessary under Medicare or other Insurance company standards. Medicare or other insurance company may deny payment for these service/products. Pro Med Inc. cannot be certain that Medicare or other Insurance company will view your doctor's request for the above listed product/service to be reasonable or necessary or that your doctor's supporting documentation will be accepted by Medicare or other insurance company. I have been advised of my privacy rights pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

□ **Check here if you would like to receive electrodes supplies for 24 month**

Patient/Legal Guardian Signature:______________________________ Date:______________