Prescription Order Form and Certificate of Medical Necessity (CMN)

Doctor:	**NPI:**
Address:	**Phone:**
	Fax:

Patient Name:	**Phone:**
*Patient Address: ______	*DOB: ______
	*SSN: ______
Cell Ph: ______	Work Ph: ______
Alt Contact:	Contact Ph:

Prescription

☐ Jaw Motion Rehab System: Standard 4.8cm wide (E1700: OraStretch™ press or TheraBite System*)

☐ with Edentulous Pads ☐ Pediatric version: (<10 yrs old, 3.1cm wide)

*Functional equivalents. We provide the OraStretch™ press unless otherwise noted.

☐ TheraPacer™ Jaw CPM: 6-12 weeks ☐ Extension of CPM unit: 12 weeks

Diag Code

*Primary: ______ Secondary: ______ Other: ______, ______, ______

(Please list 5-digit ICD9 codes and cancer codes first. Common: Effects of radiation – 990, Trismus - 781.0)

Needed by or Surgery Date (if applicable):

Reasons for Medical Necessity:______

______

______

I certify the medical necessity of this item for the above patient. The prescribed equipment is reasonable and necessary to treat the patient. This form has been accurately completed by my office, and I have reviewed it.

Provider Signature: ______ Date: ______

Patient Insurance Info

	*Primary Coverage	Secondary Coverage
*Insurance:	______	______
*Policy #:	______	______
*Ins Phone:	______	______
*Name on Ins:	______	______
*Insurance Address:	______	______

Required for WC or PIP	Adjuster: ______	CLM #: ______
	WC #: ______	Date of Injury: ______

Notes: