FAX 310-861-8754

ID#__________

RX MEDICAL NECESSITY FORM

PATIENT INFORMATION

LAST NAME | FIRST NAME | MI

GENDER | DOB | LAST FOUR OF SOCIAL | PHONE NUMBER

ADDRESS | CITY | STATE | ZIP

INSURANCE INFORMATION

☐ **WORKERS COMP (AUTO/LOP)** ☐ **SELF PARTY** ☐ **INSURANCE**

INSURANCE CARRIER | CARRIER CONTACT | MEMBER ID | GROUP

CARRIER ADDRESS | CITY | STATE | ZIP | RX BIN | PCN

PHYSICIAN INFORMATION

NAME | NPI | DEA# | FAX #

CLINIC ADDRESS | CITY | STATE | ZIP | PHONE NUMBER

PRESCRIPTION SELECTION

☐ **HCPS**:_____________- Brace Type: ☐ L ☐ R SIZE:_______

☐ **HCPS**:_____________- Brace Type: ☐ L ☐ R SIZE:_______ QTY:_______

ICD 10 CODES PRIMARY:___________ SECONDARY:___________ TERTIARY:___________ QUATERNARY:___________

MEDICAL INFORMATION

PREVIOUS TREATMENT (CHECK ALL THAT APPLY)

☐ RETARD/DIFFUSE MUSCLE ATROPHY
☐ RE-EDUCATE MUSCLES
☐ REDUCE EDEMA
☐ RETARD/DIFFUSE MUSCLE WEAKNESS
☐ INCREASE RANGE OF MOTION
☐ STIMULATE MUSCLE CONTRACTIONS
☐ PAIN CONTROL (CHRONIC)
☐ RELAX MUSCLE SPASMS
☐ PAIN CONTROL (POST SURGICAL)

PAIN LEVEL (1-10):__________________

RECOMMENDED TREATMENT DURATION: ☐ :12 MONTHS (LONG TERM) ☐_______ MONTHS (1-11)

MEDICAL HISTORY

OTHER:____

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DOCTOR NOTES:____

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PHYSICIAN SIGNATURE

Physician Verification: By my signature, I am prescribing the items listed above and certify that the above-prescribed item(s) is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

SIGNATURE: PRINT: DATE: