PRESCRIPTION AND LETTER OF MEDICAL NECESSITY

Durable medical equipment. Complete and sign.

To order: email the signed Rx to **orders@veromed.health** or fax it to **800-507-8230** with the face sheet, claim or insurance info (carrier, claim #, adjuster, DOI, employer) and recent visit notes.

VeroMed

Send to VeroMed
orders@veromed.health
Fax 800-507-8230

PATIENT _____ PHYSICIAN _____ ICD-10 _____

NPI _____ DATE OF SURGERY _____ DATE OF INJURY _____

CLAIM ☐ Workers' compensation ☐ Personal injury or auto ☐ Other

LIGHT AND INFRARED THERAPY

- ☐ SmartTriad 3LT E0221

CIRCULATION AND DVT PROPHYLAXIS

- ☐ DVT prophylaxis unit E0676
- ☐ Compression pump, adjustable gradient E0652
- ☐ Compression pump, preset pressure E0651

JOINT PAIN AND MUSCLE RECOVERY

- ☐ Joint stim
- ☐ TENS/EMS/Heat combo E0745
- ☐ Interferential and Russian stim unit

Electrodes and supplies A4595

COLD, HEAT AND COMPRESSION

- ☐ Cold compression therapy unit
- ☐ Continuous cold and hot compression unit
- ☐ Premium wraps E0667

RENTAL LENGTH ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks

CONTINUOUS PASSIVE MOTION

- ☐ CPM — knee
- ☐ CPM — shoulder
- ☐ CPM — hand and wrist
- ☐ CPM — ankle

RENTAL LENGTH ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks

ULTRASOUND AND BONE GROWTH STIMULATION

- ☐ Portable ultrasound unit
- ☐ Bone growth stimulator — spine E0748
- ☐ Bone growth stimulator — long bone E0747
- ☐ Bone growth stimulator — ultrasound (LIPUS) E0760

SPINAL AND ORTHOPAEDIC BRACING

- ☐ Cervical collar L0174
- ☐ Lumbar orthosis 627 L0627
- ☐ LSO 637 / 650 L0650
- ☐ Ligament brace w/ ROM
- ☐ Shoulder abduction sling
- ☐ SpinalQ

SIZE S M L XL 2XL 3XL 4XL

BODY PART

☐ Shoulder ☐ Knee ☐ Hand ☐ Elbow ☐ Ankle
☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Hip

SIDE ☐ Right ☐ Left ☐ Bilateral

MEDICAL NECESSITY

- ☐ Manage or reduce pain
- ☐ Reduce swelling
- ☐ Assist rehabilitation
- ☐ Post-surgical rehabilitation
- ☐ Increase range of motion
- ☐ Increase circulation
- ☐ Relax muscle spasm
- ☐ Reduce joint inflammation
- ☐ For home use only

NOTES

LETTER OF MEDICAL NECESSITY

Based on my medical review and the patient's current condition, I certify that the device marked above is medically necessary. For the best possible outcome and to speed recovery, I recommend daily use of the device as directed.

PHYSICIAN SIGNATURE _____ DATE _____

Codes shown are the manufacturer's published codes. Confirm against the payer's current fee schedule before billing.