PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

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MEDICAL NECESSITY AND PRESCRIPTION
(To be completed by ordering physician)

Patient Name		**Birth Date**	
Date of Service		**Office Contact**	
Physician Name		**Practice Name**	
NPI#	**Phone#**		**Fax#**
Address	**City**	**State**	**Zip**

PRODUCT PRESCRIBED (Check appropriate box[es]):

- ☐ DONJOY® TLSO (L0460)
- ☐ DONJOY® LSO CHAIRBACK (L0637)
- ☐ DONJOY® LSO PREMIUM PLUS (L0631)
- ☐ DONJOY® LO LOW PROFILE (L0627)
- ☐ DONJOY® LO REGULAR (L0627)
- ☐ EXOS FORM™ 627 (L0627)
- ☐ EXOS FORM™ 631 (L0631)
- ☐ EXOS FORM™ 637 (L0637)

Patient Diagnosis ICD-9 Code(s):

Describe below why this patient requires the product indicated above and attach patient chart notes.
Medical justification must be documented in the patient's medical record.

- ☐ To reduce pain by restricting mobility of the trunk or neck
- ☐ To facilitate healing following an injury to the spine, neck or related soft tissues
- ☐ To facilitate healing following a spinal procedure on the spine or related soft tissue
- ☐ To otherwise support weak neck or spinal muscles and/or a deformed spine
- ☐ Other:

By my signature, I am prescribing the items listed above. In my judgment, the above-prescribed item is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

X Physician's Signature **Date**

SALES REPRESENTATIVE INFORMATION

Sales Representative Name	Sales Representative Account # **(REQUIRED)**

A COPY OF THIS DOCUMENT SHOULD BE RETAINED IN THE PATIENT'S MEDICAL RECORD