EMPI ADVANCE ORDER FORM

Fax number: (800) 896-1798 Date _____ # of pages _____

CLINIC

Clinic Name | Date Needed

Clinic Address | City | State | Zip

Attn: Clinic Contact | Clinic Phone

REP

Sales Rep Name | Territory # | Email Address

PATIENT

Patient Name | DOB | SS#

Address | City

State | Zip Code | ( ) Telephone #

PRIMARY INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE
•PRIVATE •SELF PAY •WORKERS' COMPENSATION •AUTO •MEDICAID •MEDICARE •OTHER: _____	•PRIVATE •SELF PAY •WORKERS' COMPENSATION •AUTO •MEDICAID •MEDICARE •OTHER: _____
NAME OF INSURED / BIRTH DATE	NAME OF INSURED / BIRTH DATE
SSN / RELATION TO PATIENT	SSN / RELATION TO PATIENT
INSURANCE CARRIER	INSURANCE CARRIER
ADDRESS	ADDRESS
CITY / STATE / ZIP	CITY / STATE / ZIP
POLICY/CLAIM # / GROUP	POLICY/CLAIM # / GROUP
INSURANCE CO. PHONE # / CONTACT	INSURANCE CO. PHONE # / CONTACT
EMPLOYER OF INSURED	EMPLOYER OF INSURED

MEDICAL NECESSITY

Advance Dynamic ROM® Range of Motion Splint: Extremity: _____

☐ Right ☐ Left ☐ Flexion ☐ Extension

Primary ICD9 Code: _____ Secondary ICD9 Code: _____

Length of Need: ☐ Purchase ☐ 6-10 Months (Long Term Need) ☐ Rental # __ Months

Previous Treatment(s) Medications(s) _____

PHYSICIAN

Physician Name | Phone Number

Physician's Signature | Signature Date

I certify that the medical necessity information provided on this form is accurate and complete, to the best of my knowledge.