

Prescription Order Form and Certificate of Medical Necessity (CMN)

Provider:	NPI:
Phone:	Fax:
Address:	Office Contact and phone:

Patient:	Phone:
*Address: _____	*DOB: _____
City, State Zip: _____	*SSN: _____
Cell Phone: _____	Work Phone: _____
Alt Contact: _____	Alt Contact Ph: _____

Prescription	<input type="checkbox"/> Jaw Motion Rehab System: Standard 4.8cm wide (E1700: OraStretch™ press or TheraBite System. Functional equivalents. OraStretch™ press provided unless brand noted.)	Duration: _____ (99 months if blank)
	<input type="checkbox"/> with Edentulous Pads <input type="checkbox"/> Pediatric version (<10 yrs old, 3.1cm wide)	
	<input type="checkbox"/> TheraPacer™ Jaw CPM: 6-12 weeks <input type="checkbox"/> Extension of CPM unit: 12 weeks	

Diag Code	*Primary: _____ Secondary: _____ Other: _____, _____, _____
	(Please use 5-digit ICD9 codes and list 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	<u>*Primary Coverage</u>	<u>Secondary Coverage</u>
	*Insurance: _____	_____
	*Policy #: _____	_____
	Group#: _____	_____
	*Ins Phone: _____	_____
	*Name on Ins: _____	_____
	*Insurance Address: _____	_____

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

Notes: