CranioRehab: Prescription-Order Form & Certificate of Medical Necessity (CMN)

Prescriber:	NPI:
Phone:	Fax:
Address:	Email:
	Office Contact:

Other Requesting Provider:	☐ SLP ☐ Other:
Phone:	
Email:	☐ Request Rx from prescriber, if not attached below.

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

Prescription and CMN

☐ ***OraStretch®* Press or *TheraBite* Jaw Motion Rehab System** (E1700): Standard Version 4.8cm wide (Circle for brand required.) ☐ Add Edentulous Pads ☐ Pediatric version (<10 yrs old, 3.1cm wide) ☐ Extended jet version.	Duration: _____ Or 99 months/ Indefinite (if blank)
☐ ***Salvate*™ Oral Moisture System:** Salivary replacement, oral hydration. (E1399)	
☐ ***E-Z Flex II*:** (E1700) TMJ Exerciser	
***DynaCleft®* System** (E1399): 6-12 weeks ☐ Unilateral Strips ☐ Bilateral Strips ☐ Nasal Elevators	
☐ ***TheraPacer*™ Jaw CPM**: 6-12 weeks ☐ Extension of CPM unit: 12 weeks	

Diag. Codes (Req): *Primary: _____ 2ndary: _____ Other: _____, _____, _____
(Please use ICD-10 codes. List cancer or trauma first. Common: Effects of radiation – T66.XXXA, Trismus - R25.2.)
Needed by or Surgery Date (if applicable):

Reasons for Medical Necessity (Req): _____

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.

Prescriber Signature: **Date:**

Patient Insurance

	*Primary Coverage	Secondary Coverage
*Insurance:		
*Policy #:		
Group#:		
*Ins Phone:		
*Name on Ins:		

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

Notes:

Please return this form to Order@Craniorehab.com or by fax to 303-480-9115.

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