B&W Medical Supplies
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bwmed.net

Letter of Medical Necessity

Patient Name: _____

Diagnosis: _____

Symptoms: _____

Chronic/Intractable Pain: ☐ Mild ☐ Moderate ☐ Severe

Body Region DME Prescribed For

☐ Lumbar ☐ Cervical ☐ Hand/Wrist ☐ Knee ☐ Ankle ☐ Shoulder ☐ Elbow ☐ Other

Equipment: Please circle all that apply.

TENS/EMS/IF	Leg Spacer	Theraball	Traction	Brace	Stretch Out Strap
Analgesic Cream	Cane/Crutches	Posture Pump	Ultrasound	Wedge	Handisizer/Eggerciser
Polar Care System	Paraffin Bath	Support Pillow	Theraband	Wheelchair	Walker/Rollator

Conductive Garment : The conductive/form fitting garment is being prescribed because the patient can not manage without the use of this garment due to the large area needing to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes. The conductive/form fitting garment is being prescribed for use with the previously prescribed TENS/EMS/IF Unit.

Other _____

Length of Prescription

☐ 6 months ☐ 9 months ☐ 12+ months ☐ Other _____

Assessment/Objective Findings

☐ ↓(+) Orthopedic Findings/Test(s) ☐ ↓AROM/PROM's ☐ Muscle Spasms/Guarding ☐ (+)Radiographic Findings
☐ ↓Sensory Responses-L/R-Upper Extremity/Lower Extremity ☐ Other _____

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Slow ☐ Other _____

Previous Treatments

☐ Therapeutic Modalities ☐ Chiropractic Care ☐ Non-prescriptive Pain Medication ☐ Medical Care
☐ Prescription Medication ☐ Physical Therapy ☐ Other _____

Length of Previous Treatments: ☐ 30 days ☐ 60 days ☐ 90 days ☐ (+) 90 days

Treatment Goals

☐ Increase Ranges of Motion ☐ Decrease Effusion/Inflammation ☐ Decrease Muscle Spasms/Guarding
☐ Increase Functional Capacity/Mobility ☐ Relieve Symptomatic Pain/Management Chronic Pain
☐ Relieve Patient's Condition ☐ Decrease Need for Meds-OTC/Rx ☐ Other _____

Prescribed Usage: _____ xDaily _____ xPer Week _____ PRN(As Needed)

I certify that the above prescribed DME provided is medically necessary as a part of my treatment program for this patient. The prescribed DME is reasonable/necessary for the treatment of this patient's condition and progress. I authorize no substitution for this specific prescribed DME, as I have tried similar DME in the past with less desirable results, as they are of the highest quality & most effective DME for patient's area of concern.

Doctor's Signature NPI# Date

Doctor's Name License #

Address Phone #