CERTIFICATE OF MEDICAL NECESSITY & PHYSICIAN WRITTEN ORDER

CORPORATE HQ: Joint Active Systems, Inc., 2600 South Raney, Effingham, IL 62401
PHONE: (800) 879-0117 / (217) 342-3412 ● www.jointactivesystems.com

DIFFERENT BY DESIGN.™

TO ORDER

SEND THIS DOCUMENT, PATIENT DEMOGRAPHICS (INCLUDING A COPY OF INSURANCE CARD), CHART NOTES, & JAS® MEASUREMENT FORM
VIA FAX: (217) 347-3384 ● VIA E-MAIL: ORDERS@JOINTACTIVESYSTEMS.COM

PATIENT INFORMATION

START DATE OF ORDER (MM/DD/YY) _____ PATIENT NAME _____ PATIENT DATE OF BIRTH _____

PATIENT ADDRESS _____ PATIENT PHONE NUMBER _____

PRESCRIBED JAS® DEVICE(S)

DEVICE	AFFECTED MOTION	AFFECTED EXTREMITY(IES)	AFFECTED DIGIT(S) (IF APPLICABLE)
❑SHOULDER	❑EXTENSION	❑RIGHT	
❑ELBOW	❑FLEXION	❑LEFT	FINGER(S)
❑PRO/SUP	❑EXTERNAL ROTATION	❑BILATERAL	DIGIT ❑2nd ❑3rd ❑4th ❑5th
❑WRIST	❑INTERNAL ROTATION		
❑FINGER	❑PRONATION		TOE(S)
❑KNEE	❑SUPINATION		DIGIT ❑1st ❑2nd ❑3rd ❑4th ❑5th
❑ANKLE	❑DORSIFLEXION		
❑TOE	❑PLANTAR FLEXION		

ROM

CURRENT ROM: _____

DIAGNOSIS

PRIMARY DIAGNOSIS/ICD-9 CODE *(PLEASE PROVIDE CHART NOTES RELATED TO THIS DIAGNOSIS)* _____ DATE OF INJURY/SURGERY ONSET _____

SECONDARY DIAGNOSIS/ICD-9 CODE *(PLEASE PROVIDE CHART NOTES RELATED TO THIS DIAGNOSIS)* _____ DATE OF INJURY/SURGERY ONSET _____

LENGTH OF NEED

❑1 MONTH ❑3 MONTHS ❑4 MONTHS ❑6 MONTHS ❑10 MONTHS ❑OTHER: _____

PHYSICIANS INFORMATION AND SIGNATURE

PHYSICIAN'S NAME *(PLEASE PRINT)* _____ PHYSICIAN PHONE NUMBER _____

NPI NUMBER _____ PHYSICIAN FAX NUMBER _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

NO SUBSTITUTIONS ALLOWED! In my opinion, in accordance with accepted medical practice standards, the above named patient requires the exact JAS® device(s) as dispensed by Joint Active Systems, Inc., for the diagnosis(es) indicated.

PHYSICIAN'S SIGNATURE _____ DATE _____

ATTENTION PLEASE!

THIS FORM, PATIENT DEMOGRAPHICS (INCLUDING A COPY OF INSURANCE CARD), CHART NOTES, AND JAS® MEASUREMENT FORM ARE REQUIRED TO BILL THE PATIENT'S INSURANCE. PLEASE COMPLETE THIS FORM AND RETURN IT TO JAS® (ALONG WITH ADDITIONAL DOCUMENTS REQUESTED ABOVE) VIA THE FAX NUMBER OR E-MAIL ADDRESS TO THE RIGHT OF "TO ORDER" BOX.

DOING SO AS QUICKLY AS POSSIBLE WILL PREVENT DELAYS IN THE PROCESSING OF YOUR PATIENT'S ORDER!