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

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)	DEVICE TYPE
❑SHOULDER	❑EXTENSION	❑RIGHT	❑ STATIC PROGRESSIVE STRETCH
❑ELBOW	❑FLEXION	❑LEFT	❑ DYNAMIC STRETCH
❑PRO/SUP	❑EXTERNAL ROTATION	❑BILATERAL	❑ EMPI ADVANCE DYNAMIC STRETCH
❑WRIST	❑INTERNAL ROTATION		❑ EZ TURNBUCKLE ORTHOSIS
❑FINGER	❑PRONATION		
❑KNEE	❑SUPINATION		
❑ANKLE	❑DORSIFLEXION		
❑TOE	❑PLANTAR FLEXION		

ROM

CURRENT ROM: ____

DIAGNOSIS

PRIMARY DIAGNOSIS/ICD-10 CODE *(PLEASE PROVIDE CHART NOTES RELATED TO THIS DIAGNOSIS)* ____ DATE OF INJURY/SURGERY ONSET ____

SECONDARY DIAGNOSIS/ICD-10 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!