CERTIFICATE OF MEDICAL NECESSITY & PHYSICIAN WRITTEN ORDER

Patient Name:_____ DOB: _____

Patient Address: _____

Patient Phone #_____

Start Date of Order: _____ Date of Injury:_____ Date of Surgery: _____

Diagnosis Equipment is Prescribed for: ICD10: _____

ICD10: (2ndary)_____

Prescribed JAS Device: ☐ Shoulder ☐ Elbow ☐ Pro/Sup ☐ Wrist ☐ Finger
☐ Thumb ☐ MCP Joint ☐ Knee ☐ Ankle ☐ Toe

Affected Side: ☐ Left ☐ Right ☐ Bilateral

Length of Need: ☐ 1 month ☐ 3 months ☐ 6 months ☐ 10 months

☐ Other:_____

Affected Motion:

☐ Extension ☐ Flexion
☐ External Rotation ☐ Internal Rotation
☐ Pronation ☐ Supination
☐ Dorsiflexion ☐ Plantar Flexion

Reason Custom Equipment is Prescribed (Letter of Medical Necessity)

Custom Knee Orthotic is prescribed for this patient because the patient is unable to use a pre-fabricated Orthotic due to (please check one)

☐ Deformity of the leg or knee
☐ Size of calf or thigh
☐ Minimal muscle mass
☐ Other: _____

I certify that the above prescribed equipment is medically indicated and in my opinion, is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition and is not prescribed as "convenience" equipment. I ask that there be no equipment substitutions for the JAS devices prescribed.

Physicians Name (please Print) _____

NPI: _____ Phone #:_____

Street Address: _____ City: _____ State:_____

Physicians Signature: _____ Date: _____

PLEASE RETURN COMPLETED FORM TO:

Joint Active Systems, Inc
2600 South Raney, Effingham, IL 62401
Email: orders@jointactivesystems.com or Fax: 217-347-3384
For Questions call: 800-879-0117 or 217-342-3412