Detailed Written Order / Letter of Medical Necessity
Lantz Medical ROM Devices

Physician: Please complete all sections and fax with supporting medical records to
Lantz Medical Fax: (877) 406-4872

Patient Name: _____ Date of birth: _____

Diagnoses (**ICD 10** Codes and Descriptions): _____

Date of Injury/Onset: _____ Surgery? **YES or No**: If so when? _____

☐ **PIP Splint DYNAMIC ONLY**
Extension | Flexion
Choose one or both

☐ **Stat-A-Dyne WHFO**
☐ **Stat-A-Dyne Shoulder**
☐ **Stat-A-Dyne Wrist**
☐ **Stat-A-Dyne Elbow**
☐ **Stat-A-Dyne Pronation/Supination**
☐ **Stat-A-Dyne ESP**
☐ **Stat-A-Dyne Knee**

For Medicare patients, please also provide a detailed description of the product requested.

Narrative Description of Product: ○**Right** ○**Left** ○**Bilateral**
PIP orders (encircle digits): R 1 2 3 4 5 **L** 1 2 3 4 5

Effective Date: _____ **To be provided by:** Lantz Medical

Length of Need: _____ **ROM Parameters & Precautions**: _____

Physician Signature *(No Signature or Date Stamps please)*

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered.

By signing below, I am stating:

- I am/was treating the above-referenced patient.
- The information on this written order accurately reflects the patient's condition and the device I am prescribing.
- My medical record for this patient substantiates the prescribed use of the product.
- I will maintain a signed copy of this order in the patient's medical record file and make it available for Medicare/Insurer audit purposes.

MEDICAL NECESSITY CERTIFICATION

I, the undersigned, certify that the above prescribed equipment is medically necessary for this patient's well-being. The equipment is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of this patient's condition and is not prescribed as "convenience" equipment.

(Medicare does NOT accept signature stamp) ***(Please do NOT type in date)***

Physician Signature: _____ **Date:** _____

Physician Printed Name: _____ NPI: _____
Address: _____
Phone #: _____ Fax #: _____