LANTZ MEDICAL
Motion For Life

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

Revised
2020.10.27

Physician: Please complete all sections and fax with supporting medical records to: _____

Patient Name: _____ Date of birth: _____

Diagnoses (ICD 10 Codes and Descriptions): _____

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

◯ **Stat-A-Dyne Shoulder** ☐ Dynamic ☐ Static Progressive	◯ **Stat-A-Dyne ESP** ☐ Dynamic ☐ Static Progressive	◯ **Stat-A-Dyne Pro/Sup** ☐ Dynamic ☐ Static Progressive
◯ **Stat-A-Dyne Elbow** ☐ Dynamic ☐ Static Progressive	◯ **Stat-A-Dyne WHFO** ☐ Dynamic ☐ Static Progressive	◯ **Stat-A-Dyne Wrist** ☐ Dynamic ☐ Static Progressive
◯ **Stat-A-Dyne Knee** ☐ Dynamic ☐ Static Progressive	◯ **PIP Extension** (*Dynamic Only*) ◯ **PIP Flexsion** (*Dynamic Only*)	◯ **Vector1 Hand CPM**

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

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

Please provide from the Manufacturer only, Lantz Medical, no substiutions.

Based on last clinical visit:
☐ **My patient is not responding favorably using conventional managed methods of restoring joint motion.**
☐ **Increased stretching by incorporating a dynamic low-load stretch will only benefit the patient in regaining ROM.**

Effective Date: _____
To be provided by: LANTZ MEDICAL, INC

Length of Need: ☐ 1-3 months ☐ 4-6 months ☐ 12+ months

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 #: _____