Standard Written Order / Letter of Medical Necessity

ThuasneUSA / Lantz Medical ROM Devices

Do Not Substitute Dispense as Written

ThuasneUSA / Lantz Medical
*Phone: 866-236-8889
*Fax: 877-406-4872
*Website: www.lantzmedical.com

Physician: Complete all sections and fax with supporting medical records to: _____
(Representative Name and Fax # or Email)

Patient Name: _____ Date of birth: _____ Beneficiary ID# _____

Diagnoses (ICD 10 Codes and Descriptions): _____

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

☐ **Left** ☐ **Right** ☐ **Bilateral** ***NOTE: If a Dual hinge is desired, select both Dynamic and Static Progressive boxes.***

☐ **Vector1 Hand CPM - E0936**

☐ **Lantz Medical Elbow**
- ☐ Dynamic - E1800
- ☐ Static Progressive - E1801

☐ **Lantz Medical Ankle**
- ☐ Dynamic - E1815

☐ **Lantz Medical WHFO**
- ☐ Dynamic - E1805
- ☐ Static Progressive - E1806

☐ **Lantz Medical Pro/Sup**
- ☐ Dynamic - E1802
- ☐ Static Progressive - E1818

☐ **Lantz Medical Knee**
- ☐ Dynamic - E1810
- ☐ Static Progressive - E1811

☐ **Lantz Medical Wrist**
- ☐ Dynamic - E1805
- ☐ Static Progressive - E1806

☐ **Lantz Medical ESP**
- ☐ Dynamic - E1802
- ☐ Static Progressive - E1818

☐ **Lantz Medical Shoulder**
- ☐ Dynamic - E1840
- ☐ Static Progressive - E1841

☐ **Lantz Medical Dynamic PIP Ext - E1825**
* (Indicate digits): L ☐☐☐☐☐ (1 2 3 4 5) R ☐☐☐☐☐ (1 2 3 4 5)

☐ **Lantz Medical Dynamic PIP Flex - E1825**
* (Indicate digits): L ☐☐☐☐☐ (1 2 3 4 5) R ☐☐☐☐☐ (1 2 3 4 5)

Narrative Box:

Based on last clinical visit:

☐ My patient is not responding favorably using conventional managed methods of restoring joint motion.

☐ Increased stretching by incorporating a low-load stretch will only benefit the patient in regaining ROM.

To be provided by: LANTZ MEDICAL, INC *(no substitutions).*

Order Date: _____ **Length of Need:** _____ **months.**

Physician Signature *(No Signature Stamps)*

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. 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 a signature stamp)

⟹ **Physician Printed Name:** _____ **NPI:** _____

Address: _____ **Phone:** _____ **Fax:** _____

⟹ **Physician Signature:** _____ **Date:** _____