Anodyne

Home Cervical Traction Letter of Medical Necessity

Patient Name: ________________________________ **Date of Birth:** _____/_____/____

Patient Address:________________________________ City: ________________Zip: __________

Patient Phone: □ Home □ Cell ____

Qualifying Information

Does patient have a musculoskeletal or neurological impairment? □ Yes □ No

Has appropriate use of device been demonstrated and tolerated by patient? □ Yes □ No

Diagnoses Require Home Cervical Traction? □ Yes □ No

ICD-10 Code(s): ______________________________ Date of Last Appointment:____________________

Length of Need: __________________(In months; 99= lifetime)

Physician's Certification / Prescription	
Please provide the above patient with the following: □ One Cervical Traction Device	**Please check all that apply** □ Physician has ordered more than 20 pounds of force. □ Patient has a diagnosis of TMJ dysfunction AND has received treatment for the condition. □ Patient has a distortion of the lower jaw or neck anatomy (e.g., radial neck dissection) preventing the use of a chin halter.

All of the information contained in this statement is true and correct to the best of my knowledge. By my signature below, I authorize the use of this documents by a licensed pharmacy as a dispensing authorization and certification of medical need

Physician : ____ **NPI:**________________________

Phone: ______________________________________ **Fax:**____________________________

Signature: ____ **Date:** _______/_______/_______

STAMPED SIGNATURE AND DATES ARE NOT ACCEPTABLE

Please include pertinent medical records to and fax to:

Anodyne Home Medical - 6024 Blue Circle Drive Minnetonka, MN 55343 **FAX: (763) 486-1365**