DWO for Cervical Traction/Therapy Collar

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622

DATE OF ORDER:_________________
DATE OF LAST FACE TO FACE:___________________

PATIENT INFORMATION

First Name____________________________________ **Last Name**____

Address_________________________ **City**________________ **State**________ **Zip**__________ **Phone**______________

Date of Birth_________ **Emergency Contact**_______________________ **Emergency Contact Phone**________________

REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name____ **Therapist Name** _______________________________

Clinic Address_________________________________ **City**______________________ **State**________ **Zip**_________

Phone____________________**Fax**______________________**Therapist Email**________________________________

PRODUCT PRESCRIBED

☐ Cervical Home Traction Unit (E0849)
☐ Cervical Therapy Collar, Multi-Post, Adjustable (L0180)
☐ Other_________________________

LENGTH OF NEED AND MEDICAL NECESSITY

☐ Purchase (99=Lifetime)

Previous Treatments/Medications

☐ Prior Surgery ☐ NSAIDS ☐ Physical Therapy ☐ Pain Medications ☐ Injections Other___________

DIAGNOSIS

☐ **Primary ICD10 Numeric Code:**____________________ **Secondary ICD10 Numeric Code:**____________________

CERVICAL TRACTION ONLY – MEDICARE/MEDICAID COMPLETION REQUIRED

Medicare requires that we maintain documentation to support the need for a cervical traction device. Please ensure that all information below is substantiated by the patient's medical record. Please attach patient's medical records as supporting documentation.

1.	Patient has a musculoskeletal or neurological impairment requiring the use of this equipment?	☐ Yes	☐ No
2.	Appropriate use has been demonstrated and the device was tolerated by the patient?	☐ Yes	☐ No

Justification: *Pneumatic Cervical Traction vs. Over-The-Door Traction*

1.	Physician has ordered more than 20 pounds of force (must be documented in patient medical record).	☐ Yes	☐ No
2.	Patient has a diagnosis of TMJ dysfunction and has received treatment for this condition.	☐ Yes	☐ No
3.	Patient has a distortion of the lower jaw or neck anatomy (e.g. radical neck dissection) preventing the use of a chin halter.	☐ Yes	☐ No

PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried or considered and ruled out.

Physician Name__________________________ **NPI#**_______________ **Phone**______________ **Fax**_______________

Physician Address_______________________________________ **City**________________ **State**________ **Zip**_________

Physician Signature____ **Date Signed**______________________________