CERTIFICATE OF MEDICAL NECESSITY

Please visit our website at www.trinitidmesolutions.com

Email to scripts@trinitidmesolutions.com
Fax to 888-549-9793

Patient Name:_____ Patient Date of Birth: _____

Patient Insurance: **BCBS**_____**AETNA** _____**UHC**_____ Patient's ID:_____

Duration: Patient has had chronic pain for _____ Months_____ Years

SPINAL PROTOCOL	
☐ Digital TENS/EMS Unit ☐ Electrodes ☐ Lumbar Traction Device ☐ Universal Lumbar Back Brace	☐ Disc Degeneration (M51.36) ☐ Spinal Stenosis (M48.04) ☐ Segmental and Somatic dysfunction (M99.03) ☐ Lumbar Strains (S33.5XXA) ☐ Other: _____
CERVICAL EQUIPMENT ☐ Cervical Collar ☐ Cervical Garment ☐ Cervical Traction Device	☐ Dysfunction of Cervical Region (M99.01) ☐ Cervical Disc Degeneration (M50.33) ☐ Sprain of Cervical Spine (S13.4XXA) ☐ Cervical Spinal Stenosis (M48.02) ☐ Other: _____
ADDITIONAL EQUIPMENT ☐ Lumbar Garment ☐ Back Brace Extension (2X or Larger) ☐ Peak Scoliosis Brace	
WARRIOR KNEE BRACE ☐ Small ☐ Medium ☐ Large ☐ XL ☐ XXL	☐ Sprain of Lateral Collateral Ligament (S83.429A) ☐ Sprain of Medial Collateral Ligament (S83.419A) ☐ Patellar Tendinitis (M76.50) ☐ Other: _____
ANKLE BRACE ☐ *Left* ☐ *Right* ☐ Small ☐ Medium ☐ Large	☐ Sprains/Strain of Tibiofibular Ligament (S93.439A) ☐ Osteoarthritis, Ankle & Foot (M19.079) ☐ Other: _____
SHOULDER BRACE ☐ Small ☐ Medium ☐ Large ☐ Extra Large	☐ Sprains/Strains of Shoulder (M24.419) ☐ Calcifying Tendinitis of Shoulder (M75.30) ☐ Other: _____
ELBOW BRACE ☐ Small ☐ Medium ☐ Large ☐ Extra Large	☐ Radial Collateral Sprain/Strain (S53.439A) ☐ Ulnar Collateral Sprain/Strain (S53.499A) ☐ Other: _____
WRIST BRACE ☐ Universal	☐ Sprain of Carpal Joint (S63.519A) ☐ Osteoarthritis (M19.049) ☐ Carpel Tunnel Syndrome (G56.00) ☐ Other: _____

Please Check Treatment Goals:

_____ Reduce Muscle Spasm _____ Disc Hydration _____ Increase Range of Motion _____ Control Edema
_____ Manage Chronic Pain _____ Correct Posture _____ Reduce Reliance on Narcotics _____ Stabilization

Equipment Length of Time Prescribed: 12-18 Months 18-24 Months Lifetime Other: _____

I certify that the above prescribed equipment is medically necessary and, in my opinion, is reasonable and necessary to effectuate a maximum and expedient recovery with reference to the standards of medical practice and treatment of this patient's condition.

Doctor's Name Printed:_____ Date: _____

Doctor's Signature: _____