SMG MEDIQUIP LLC
SUPERIOR PRODUCTS, SUPERIOR SERVICE

SMG Mediquip, LLC
P.O. Box 736
Bethpage, NY 11714-0736
Phone: 516.586.4934
Fax: 800-717-2573
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www.smgmediquip.net

PRESCRIPTION FORM/LETTER OF MEDICAL NECESSITY

PATIENT INFO:
(Complete only the information in this section that has not been provided on previously submitted forms)

Patient Name:	**Check One:** Male X Female ___
Street Address:	**City, State, Zip:**
Mobile Phone:	**Check One:** Major Med X Workers Comp ___ No-Fault ___
Social Security Number:	**Date of Injury/Accident (if applicable):**

ITEM(S) PRESCRIBED: X **TENS** ___ **PRONEX CTU:** REG LG WIDE X **LUMBAR BRACE**

Other: ___

RECOMMENDED USAGE: ___ Daily 3-4 x Per Wk **PERIOD OF MED NECESSITY (circle one):** (6 mo) 9 mo. 12 mo.

AREA(S) TO BE TREATED: X Lumbar Spine ___ Thoracic Spine ___ Cervical ___ Other (indicate: ___)

ICD-10 DIAGNOSIS CODES:

Lumbar Codes: __M54.6 X M54.5 X M99.03 __M43.27 __M51.36 Other: ___

Cervical Codes: __M99.01 __S23.3XXA __M54.2 __M50.30 __M62.40 Other: ___

Other ICD-10 Codes (If applicable): ___

I PRESCRIBE THIS EQUIPMENT BECAUSE (Symptoms/Objective Findings): CHRONIC LOW BACK PAIN. LIMITED ROM ALL PLANES. POS. GAENSLENS, NACHLAS HIBBS. MARKED INFLAMM PAIN L2-5 BILAT.

TREATMENT GOALS: X Relieve Patient's Condition ___ Increase Range of Motion X Manage Chronic Pain

X Achieve Stabilization ___ Reduce Muscle Spasm ___ Reduce Reliance on Pain Medications ___ Disc Hydration

PAIN SEVERITY: (Chronic) Severe Intractable Mild Moderate **PROGNOSIS:** Excellent Good Fair (Guarded)

PREVIOUS TREATMENTS: E. STIM, U. SOUND, TX, NSAIDS, CHIRO ADJS.

DATE OF INITIAL VISIT: 1/16/17 **DATE LAST SEEN:** 10/5/17

I certify that the above prescribed equipment, provided by SMG Mediquip, LLC, is both reasonable and medically necessary, unless otherwise noted.

PHYSICIAN NAME: ___ **PHONE:** ___

PHYSICIAN SIGNATURE: ___ **DATE:** ___

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PRESCRIPTION FORM/LETTER OF MEDICAL NECESSITY

PATIENT INFO:
(Complete only the information in this section that has not been provided on previously submitted forms)

Patient Name:	**Check One:** Male ✓ Female ___
Street Address:	**City, State, Zip:** 11742
Mobile Phone:	**Check One:** Major Med ___ Workers Comp ___ No-Fault X
Social Security Number:	**Date of Injury/Accident (if applicable):** 4-5-17

ITEM(S) PRESCRIBED: ___ TENS X **PRONEX CTU:** REG LG WIDE ___ **LUMBAR BRACE**
Other: ___

RECOMMENDED USAGE: ___ Daily 3-5 x Per Wk **PERIOD OF MED NECESSITY (circle one):** 6 mo. 9 mo. 12 mo.

AREA(S) TO BE TREATED: ___Lumbar Spine ___ Thoracic Spine X Cervical ___Other (indicate: ___)

ICD-10 DIAGNOSIS CODES:

Lumbar Codes: ___M54.6 ___M54.5 ___M99.03 ___M43.27 ___M51.36 Other: ___

Cervical Codes: X M99.01 X S23.3XXA X M54.2 X M50.30 ___M62.40 Other: S16.1XXA

Other ICD-10 Codes (if applicable): ___

I PRESCRIBE THIS EQUIPMENT BECAUSE (Symptoms/Objective Findings): Neck pain with Radiculopathy x radiation down both arms. + foraminal compression + Spto Hall + cervical distraction decreased ROM w pain in cervical paraspinal area/tenderness

TREATMENT GOALS: X Relieve Patient's Condition X Increase Range of Motion X Manage Chronic Pain
X Achieve Stabilization X Reduce Muscle Spasm X Reduce Reliance on Pain Medications X Disc Hydration

PAIN SEVERITY: Chronic (Severe) Intractable Mild Moderate **PROGNOSIS:** Excellent (Good) Fair Guarded

PREVIOUS TREATMENTS: Pain management Epidural Chiropractic

DATE OF INITIAL VISIT: 4-7-17 **DATE LAST SEEN:** 9-20-17

I certify that the above prescribed equipment, provided by SMG Mediquip, LLC, is both reasonable and medically necessary, unless otherwise noted.

PHYSICIAN NAME: ___ **PHONE:** ___

PHYSICIAN SIGNATURE: ___ **DATE:** ___

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PATIENT INFO:
(Complete only the information in this section that has not been provided on previously submitted forms)

Patient Name:	Check One: Male ___ Female ✓
Street Address:	City, State, Zip:
Mobile Phone:	Check One: Major Med ___ Workers Comp ___ No-Fault___
Social Security Number:	Date of Injury/Accident (if applicable): 8/6/2017

ITEM(S) PRESCRIBED: ✓ TENS ✓ PRONEX CTU (REG) LG WIDE ✓ LUMBAR BRACE

Other: _____

RECOMMENDED USAGE: 3 Daily 7 x Per Wk PERIOD OF MED NECESSITY (circle one): 6 mo. 9 mo. (12 mo.)

AREA(S) TO BE TREATED: ✓ Lumbar Spine ___ Thoracic Spine ✓ Cervical ___ Other (indicate: _____)

ICD-10 DIAGNOSIS CODES:

Lumbar Codes: __M54.6 __M54.5 ✓M99.03 __M43.27 __M51.36 Other: M5416

Cervical Codes: ✓M99.01 __S23.3XXA __M54.2 __M50.30 __M62.40 Other: S13.150A

Other ICD-10 Codes (if applicable): M99.02, S23.132A.

I PRESCRIBE THIS EQUIPMENT BECAUSE (Symptoms/Objective Findings): (+) Exam Findings including decreased Range of Motion, Musck Spasm, Pain on Palpation, (+) X-RAY findings.

TREATMENT GOALS: ✓ Relieve Patient's Condition ✓ Increase Range of Motion ✓ Manage Chronic Pain
___Achieve Stabilization ✓ Reduce Muscle Spasm ___Reduce Reliance on Pain Medications ___Disc Hydration

PAIN SEVERITY: (Chronic) (Severe) Intractable Mild Moderate PROGNOSIS: Excellent Good Fair (Guarded)

PREVIOUS TREATMENTS: Conservative chiropractic Care, Electric Stim, etc.

DATE OF INITIAL VISIT: 9/20/17 DATE LAST SEEN: 10/16/17

I certify that the above prescribed equipment, provided by SMG Mediquip, LLC, is both reasonable and medically necessary, unless otherwise noted.

PHYSICIAN NAME: _____ PHONE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____