



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 _____

PRODUCT PRESCRIBED

Cervical Home Traction Unit (E0849)

Other _____

Cervical Therapy Collar, Multi-Post, Adjustable (L0180)

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Appropriate use has been demonstrated and the device was tolerated by the patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Patient has a diagnosis of TMJ dysfunction and has received treatment for this condition.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 _____