



PRESCRIPTIONS

VITALWEAR

384 OYSTER POINT BLVD., SUITE 16
SOUTH SAN FRANCISCO, CA 94080 800.553.4081

PATIENT INFORMATION

(please attach or fill in required information)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE - HOME _____ WORK _____

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ SEX M F

RELATIONSHIP TO INSURED _____

INSURANCE INFORMATION

(please attach or fill in required information)

INSURED'S NAME/
EMPLOYER (W/C) _____

INSURANCE CO. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ SUBSCRIBER _____

POLICY# _____ GROUP# _____

EMPLOYER W/C CLAIM# _____

AUTO CLAIM# _____

PRE AUTH# _____

DOCTOR INFORMATION

(may use stamp)

DR'S NAME _____ MD DPM DO

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

UPIN _____

THE PHYSICIAN CERTIFIES THE FOLLOWING APPROPRIATE ICD-9 CODES (LIST OR CIRCLE BELOW)

714.0	Rheumatoid Arthritis	721.90	Spondylosis
714.89	Other specified inflammatory polyarthropathies	722.52	Degeneration of thoracic or lumbar intervertebral disc
715.90	Osteoarthritis, unspecified whether generalized or localized	724.20	Lumbago – low back pain
716.90	Arthropathy, unspecified	724.3	Sciatica
721.3	Cervical spondylosis without myelopathy	Other:	_____

PROOF OF DELIVERY, AND AUTHORIZATION TO RELEASE INFORMATION AND PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER, VITALWEAR INC.

I have received the above product as prescribed by my physician. I authorize my physician to release VitalWear Inc. ("VitalWear") and for VitalWear to release to my insurer any needed information for this or a related claim. I request that payment of authorized benefits be made on my behalf, and I assign the benefits payable for the medical equipment provided by VitalWear to VitalWear or its affiliates. Although I recognize that I have the primary responsibility for contacting and submitting claims to my insurer, I have received the equipment and authorize VitalWear to submit a claim to any of the insurers as may be required. I understand that I am responsible for deductibles and co-payments not covered by my insurance. Should my insurance plan not provide coverage in its entirety for any reason, I understand that I may be responsible for payments.

I was hereby given advance notice that Medicare does not pay for cold therapy products obtained from VitalWear. I understand that because these items are excluded from Medicare coverage I am responsible for payment to VitalWear.

PATIENT/
AUTHORIZED SIGNATURE _____ DATE _____

Your signature on this form indicates that you have received the prescribed product.

PRODUCT SERIAL NUMBER: _____

PATIENT REQUIRES:

QTY.

- 00002 VitalWrap System, 120V_{ac}, 60Hz with Standard 6" x 60" VitalWrap PLUS:
- 00013 VitalWrap System, 120V_{ac}, 60Hz PLUS:
- 00395 Large Shoulder VitalWrap 00119 Shoulder VitalWrap
- 00255 Medium VitalWrap, 4-1/4" x 52" 00392 Full Knee VitalWrap
- 00001 Standard VitalWrap, 6" x 60" 00397 Medium Knee VitalWrap
- 00118 Large VitalWrap, 8" x 72" 00394 Wrist VitalWrap
- 00396 Dual Hand VitalWrap 00122 Cervical VitalWrap
- 00398 Ankle VitalWrap

- DME CODE: E0217 WATER CIRCULATING HEAT PAD W/ PUMP E0218 WATER CIRCULATING COLD PAD W/ PUMP
- E0236 PUMP FOR WATER CIRCULATING PAD E0249 PAD FOR WATER CIRCULATING HEAT UNIT
- A9900 MISCELLANEOUS DME ACCESSORY OR SUPPLY

DISPENSED TO PATIENT INITIALS _____

DATE OF SURGERY _____

LENGTH OF NEED: DAYS 1-3 MONTHS 3-6 MONTHS 6+ MONTHS

HOURS OF USE: TIMES PER DAY:

THE PATIENT HAS BEEN SUFFERING FROM THIS CONDITION FOR:

MONTHS YEARS (Chronic = 3 months or more)

PREVIOUS MEDICATION(S) AND/OR THERAPY TREATMENTS HAVE BEEN:

THE FOLLOWING CONTRAINDICATIONS ARE PRESENT THAT PROHIBIT THE USE OF ELECTRIC HEATING PADS, HOT PACKS, OR PAIN MEDICATIONS:

- Oxygen rich environment Patient consciousness or safety awareness
- Drug interactions Restricted pain medications due to medical condition (e.g., stroke)

Explain: _____

- The VW System provides therapy that cannot be achieved by electric heating pad or hot packs.
- The VW System delivers hours and/or overnight continuous temperature therapy necessary for treatment of the patient.
- The VW System is safer to use and reduces the risk of injury compared with electric heating pads or hot packs.

DESCRIPTION OF TREATMENT(S) PROVIDED BY THE VW SYSTEM FOR THE ABOVE PATIENT (check all that apply):

- Improve circulation Reduce pharmaceutical usage Amputation prevention
- Wound therapy Increase joint range of motion Drug free pain relief
- Chronic pain Nerve damage Use while sleeping Relax muscles
- Increase blood oxygen perfusion (PI) Hypertension/High blood pressure

Explain: _____

LETTER OF MEDICAL NECESSITY

REASONS FOR NEED / MEDICAL NECESSITY

- INCREASED FUNCTIONAL ACTIVITY FORTIFY JOINT STABILITY REDUCE SWELLING

OTHER: _____

VitalWear has supplied this unit as per the above prescription. I recommend this particular device for home use as part of the patient's physical therapy treatment.

—DISPENSE AS WRITTEN. DO NOT SUBSTITUTE—

PHYSICIAN'S SIGNATURE _____ DATE _____