



# 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	721.3	Lumbosacral spondylosis without myelopathy
714.8	Other specified inflammatory polyarthropathies	721.9	Spondylosis
715.9	Osteoarthritis, unspecified whether generalized or localized	722.5	Degeneration of thoracic or lumbar intervertebral disc
716.9	Arthropathy, unspecified	724.2	Lumbago – low back pain
721.0	Cervical spondylosis without myelopathy	724.3	Sciatica

## 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<sub>ac</sub>, 60Hz with Standard 6" x 60" VitalWrap PLUS:

00013 VitalWrap System, 120V<sub>ac</sub>, 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 \_\_\_\_\_