



VITALWEAR

PRESCRIPTIONS

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 _____

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:

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

INJURY DIAGNOSIS	C-SPINE	T-SPINE	L-SPINE	AC JOINT CLAVICLE	SHOULDER	SCAPULA	HUMERUS	ELBOW	FOREARM	WRIST	HAND	FINGER	PELVIS	HIP	FEMUR	PATELLA	LEG	ANKLE	FOOT	TOE
Fracture	805.00	805.2	805.4	810.03	—	811.0	812.2	813.00	813.20	814.00	815.00	816.00	808.8	820.8	821.00	822.0	823.8	824.8	825.20	826.0
Disloc.	839.00	839.21	839.20	831.04	831.0	831.9	831.0	832.0	839.8	833.0	839.8	834.0	839.69	835.0	—	836.3	839.8	837.0	838.0	838.09
Spr./Str.	847.0	847.1	847.2	840.0	840.9	840.9	840.9	841.9	841.9	842.0	842.1	842.1	848.9	843.9	843.9	844.9	844.9	845.0	845.1	845.1
Confusion	922.31	922.3	922.3	923.00	923.00	923.01	923.03	923.11	923.10	923.21	923.20	923.3	922.9	924.01	924.0	924.11	924.10	924.21	924.20	924.3
Tend/Burs	—	—	—	—	726.1	—	—	726.30	—	726.4	726.4	726.4	—	726.5	—	726.60	726.71	726.7	726.7	726.79
Wound	876.0	876.0	876.0	—	880.0	880.01	880.03	881.01	881.00	881.02	882.0	883.0	879.6	890.0	890.0	891.0	891.0	891.0	892.0	893.0
DJD	721.0	721.2	721.3	715.11	715.11	—	—	715.12	715.13	715.14	715.04	715.04	—	715.15	715.15	715.16	715.16	715.17	715.07	715.07
BACK AND NECK					Shoulder Capsulitis			KNEE					Hammer Toe		735.4		Osteoporosis			733.0
Radiculitis		723.4			Biceps Tendonitis			Chondromalacia			717.7		Hallux Rigidus		735.2		Osteomyelitis			730.00
Cerv. Disc. Hern.		722.2			Impingement Syndrome			Baker's Cyst			727.51		Sesamoiditis		733.99		Devel Disloc. Hip			754.3
Thoracic Kyphosis		737.10			Rotator Cuff Tear			Tear Med. Meniscus			836.0		Pes Planus		754.61		Infection			136.9
Scoliosis		737.30			HAND AND WRIST			Tear Lat. Meniscus			836.1		Achilles Tendon Rupture		845.09		Lower Limb Def.			755.30
Facet Arthritis		724.9			DeQuervain's			Tear Ant/Post Cruc. Lig.			844.2		Hallux Valgus		735.0		Synovitis			727.0
Lumber Disc. Hern.		722.10			Trigger Finger			Tear Med. Coll. Lig.			844.1		Osteochondrosis		732.5		Tib. Torsion			736.89
Spondylolisthesis		756.12			Dupuytren's Contracture			Tear Lat. Coll. Lig.			844.0		Osteochondritis		732.7		Non-Union			733.82
Sciatica		724.3			Ganglion			Loose Bodies			717.6		Gout		274.9		Foreign Body			729.6
Lumbar Spinal Ste		724.02			Colles' Fracture			Osgood Schlatter's Dis.			732.4		Tarsomet Disloc.		838.03		Joint Effusion			719.00
Sacrum/Coccyx Fx		805.6			Carpal Tunnel Synd.			Internal Derangement			717.9		Metatarsalgia		726.70		Hemarthrosis			719.10
Lumbar Radiculopathy		724.4			Cubital Tunnel Synd.			FOOT					MISCELLANEOUS				Osteochoncl Dis.			732.7
Cervical Radiculopathy		723.4			Gamekeeper's Thumb			Plantar Fasciitis			728.71		Osteoarthritis		715.10		Fem Version			755.63
SHOULDER AND ELBOW					Mallet Finger			Morton's Neuroma			355.6		Rheumatoid Arthritis		714.0		Av. Necrosis			733.40
Lat. Epicondylitis		726.32			Neur. Ulnar/Radia			Tibialis Tendinitis			726.72		Ret. Hardware		996.67		Rib Fx			807.00
Olecranon Bursitis		726.33															Cerebral Palsy			343.9

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: _____

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 _____