



Traction Prescription & Assignment of Benefits

FAX TO:

NOTE: When submitting this request please include patient's complete demographic information and a copy of his/her insurance card if available.

Clinic Information

Ship To: Home Clinic

Clinic Name _____ Acct# _____ Phone _____ Fax _____

Clinic Address _____ City _____ State _____ Zip _____ Contact _____

Sales Representative _____ Territory # _____ Phone _____ Fax _____

Patient Assignment of Benefits/ Release of Information

Private Medicare Workers Compensation Self Pay Medicaid Auto: Date of Injury _____

Patient Name _____ Date of Birth _____ SS# _____ Phone _____

Address _____ City _____ State _____ Zip _____ Alternate Phone _____

Insurance _____ Policy/Claim # _____ Group # _____ Phone _____

Secondary Insurance _____ Policy/Claim # _____ Group # _____ Phone _____

Emergency Contact _____ Emergency Contact Phone _____

I hereby authorize payment of medical benefits to Empi for services furnished. I further authorize the release of any medical information required for treatment, payment and healthcare operations. I understand that any balance remaining relative to the cost of the device and/or supplies after my insurer has remitted appropriate payment and Empi has taken applicable discounts will be my responsibility. In addition, I understand that, upon receipt of the device, I will receive Empi's Notice of Privacy Practices and the Patient Bill of Rights. My signature below acknowledges understanding of the above referenced terms and conditions of this agreement.

*Patient Signature _____ Date of Signature _____

*REQUIRED FOR HOME DELIVERY

By initialing here _____ I agree to have this product shipped directly to my home address.

Guarantor/Legal Representative (if patient unable to sign): _____

DEVICE REQUESTED: Saunders® Cervical Home Traction Saunders® Lumbar Home Traction

MEDICAL NECESSITY / LENGTH OF NEED ICD-9 CODES

Purchase (1-99 = Lifetime) 6-10 Months Rental # _____ months

Primary ICD-9 Code _____ Secondary ICD-9 Code _____

Previous Treatment(s)/ Medications _____

CERVICAL TRACTION Medicare/Medicaid

Medicare requires that we maintain documentation to support the need for a cervical traction device. Please ensure that all information below is consistent with your patient's medical record.

- 1. Patient has a musculoskeletal or neurological impairment requiring the use of this equipment? YES NO
- 2. Appropriate use has been demonstrated and the device was tolerated by the patient. YES NO

Justification - Pneumatic Cervical Traction Versus Over-The-Door Traction.

- 3. Physician has ordered more than 20 pounds of force (must be documented in medical record). YES NO
- 4. Patient has a diagnosis of TMJ dysfunction and has received treatment for this condition. YES NO
- 5. Patient has a distortion of the lower jaw or neck anatomy (e.g., radical neck dissection) preventing the use of a chin halter. YES NO

Physician Name _____ NPI# _____ Phone _____

*Physician Signature _____ Date of Signature _____

*REQUIRED FOR HOME DELIVERY

I certify that the medical necessity information provided on this form is accurate and complete to the best of my knowledge. *Please note Medicare will no longer accept signature stamps. Please make sure the above information is substantiated in your patient's medical record.

Do Not Substitute

