GLOBAL HMD
GLOBAL HEALTH MEDICAL DEVICES

PRESCRIPTION AND LETTER OF MEDICAL NECESSITY

Patient Name:	**Date of Birth:** ____/____/_____	**Date of Injury:** ____/____/_____
Check all that apply: ☐ Left ☐ Right ☐ Bilateral	**Duration:**	**Date of Surgery:** ____/____/_____
Diagnosis Code(s):	**Set up type:** ☐ Surgical ☐ Non-Surgical	

☐ Cold~Hot~Contrast~Circulatory and DVT Compression Therapies ☐ No Substitutions

Check all that apply:

- ☐ Foot/Ankle
- ☐ Knee Intermittent
- ☐ Hip
- ☐ Elbow
- ☐ Shoulder
- ☐ Hand/Wrist
- ☐ Spine: ☐ Thoracic ☐ Cervical ☐ Lumbar

Check appropriate therapies below:

- ☐ Intermittent Cold Compression Therapy NO DVT (E1399)
- ☐ Cold Compression Therapy WITH DVT (E0676)

DESCRIPTION

Intermittent Cold Compression Therapy device triggers the body's natural anti-inflammatory process. It has been clinically proven to reduce pain and swelling, pushes fluids away from the traumatized areas, and provides lasting relief without the use of pain modifications by means of a safe and clinically proven therapy.

Diagnosis - Check all that apply

- ☐ Cervical Pain (M 54.2)
- ☐ Lumbar Area Pain (M 54.5)
- ☐ Thoracic Spine Pain (M 54.6)
- ☐ Left Knee Pain (M 25.562)
- ☐ Left Leg Pain (M 79.605)
- ☐ Other
- ☐ Cervical Radiculopathy (M 54.12)
- ☐ Lumbar Radiculopathy (M 54.16)
- ☐ Hip Pain (M 25.55)
- ☐ Right Knee Pain (M 25.561)
- ☐ Right Leg Pain (M 79.604)
- ☐ Left Shoulder Pain (M 25.512)
- ☐ Right Shoulder Pain (M 25.511)
- ☐ Ankle/Foot Joint Pain (M 25.57)
- ☐ Left Wrist Pain (M 25.532)
- ☐ Right Wrist Pain (M 25.531)

Medical Necessity

The above devices are being prescribed to reduce, correct, or ameliorate, the physical, mental, developmental, or behavioral effects of an illness, injury, condition, or disability. I certify that the device(s) I am prescribing are medically necessary to treat the specific medical condition described above, and is not for general food health or cosmetic purposes. I also certify that the device(s) will assist individuals to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

Provider Name _____ Date _____

Provider Signature _____ NPI _____

Send completed form with patient demographics via email: **billing@globalhmd.com** **OR** fax **(248) 965-9126**

For Billing or Patient questions call or text: **(248) 658-3249**

08042023