Statement of Medical Necessity for
Water Circulating Heat Pad with Pump

Patient Name_____
Last First Middle

Address_____
City State Zip Code

Date of Birth _____ Male ☐ Female ☐ Medicare # _____

I hereby certify that the following equipment is medically necessary as part of the patient's treatment program. I certify that the following statement(s) are true.

The water circulating heat pad with pump provides a therapeutic benefit that is not achieved solely by using a standard electric heat pad, such as increased safety, delivery of a specific temperature, and contour to treatment site. Specifically therapeutic for those who are susceptible to burns, i.e. diabetics.

Patient requires: A water circulating heat pad with pump – this modality provides localized heat therapy that is safe and effective (HCPCS E0217). Adjustable temperature from 30F to 120F (105F fixed for sensitive skin on low heat setting) providing controlled heat (water) within safe limits that relaxes muscles, increases blood flow and reduces edema as well as pain. Patented therapy pads are used for treatment (HCPCS E0249).

Please specify body part(s) needing therapy _____

Diagnosis: ☑ Please check all that apply

☐714.00 Rheumatoid Arthritis ☐714.89 Inflamm Polyarthrop-NEC ☐715.90 Osteoarthrosis NOS-Unspec

☐728.85 Muscle Spasm ☐721.30 Lumbosacral Spondylosis ☐721.90 Spondylosis NOS w/o Myelop

☐724.30 Sciatica ☐782.30 Edema ☐459.80 Poor Circulation

ICD9 needed: Chronic pain _____ Inflammation _____ Neuropathy _____ Traumatized Tissue ____

Other diagnosis: _____

Therapeutic use is for: _____
(ex. Increased circulation, reduction of pain or inflammation, increased mobility etc)

Estimated Length of need (# of months): _____ 1- 99 (99=lifetime)

Usage:_____ Hours:_____ Per day _____ or Continuous ____

(Check skin every 20 minutes for possible adverse reactions.)

What other treatments have been tried? _____

Physician agrees to keep chart notes on file as they pertain to this product.

_____
Physician Name UPIN # or NPI#

_____
Address City State Zip Code

_____
Office Phone Office Fax

✍* _____
Attending Physician Signature (Original Signature Only – No Stamps) Date