Anodyne

Home Cervical Traction Letter of Medical Necessity

Patient Name: _____ Date of Birth: _____/_____/____

Patient Address: _____ City: _____Zip: _____

Patient Phone: ☐ Home ☐ Cell _____

Qualifying Information

Does patient have a musculoskeletal or neurological impairment? ❑ Yes ❑ No

Has appropriate use of device been demonstrated and tolerated by patient? ❑ Yes ❑ No

Diagnoses Require Home Cervical Traction? ❑ Yes ❑ No

ICD-10 Dx Code(s): _____ Date of Last Appointment: _____

Length of Need: _____ (In months; 99 = lifetime use)

Physician's Certification / Prescription

Please provide the above patient with the following:

☐ One Cervical Traction Device

Date of the order (required):

_____/_____/_____

Please check all that apply

☐ Physician has ordered more than 20 pounds of force.

☐ Patient has a diagnosis of TMJ dysfunction AND has received treatment for the condition.

☐ Patient has a distortion of the lower jaw or neck anatomy (e.g., radial neck dissection) preventing the use of a chin halter.

I have completed and/or reviewed all the information contained in this statement and it is true and correct to the best of my knowledge. By my signature below, I authorize the use of this document by a licensed Durable Medical Equipment supplier as a detailed written order authorization and certification of medical need.

Physician : _____ NPI:_____

Phone: _____ Fax:_____

Signature: _____ Date: _____/_____/_____

STAMPED SIGNATURE AND DATES ARE NOT ACCEPTABLE

Please include supporting medical records to and fax to:

Anodyne, Inc. 6024 Blue Circle Drive Minnetonka, MN 55343 ♦ 952-546-5334 **FAX: (952) 546-2657**