PainRay RX & LETTER OF MEDICAL NECESSITY FORM

PRESCRIBING DOCTOR'S NAME | NPI #

CLINIC ADDRESS | CITY | STATE | ZIP

OFFICE PHONE # | EMAIL

PATIENT'S NAME | **DATE OF BIRTH** | **DATE OF INJURY**

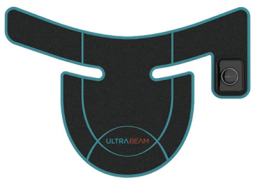
PHONE # | **ATTORNEY NAME / EMAIL**

PATIENT'S SHIPPING ADDRESS | **STATE** | **ZIP**

RED LIGHT THERAPY

DX CODE (S) _____

☐ **LOWER BACK PAD**



☐ **NECK PAD**

☐ **KNEE PAD**

☐ **HAND PAD**

☐ **SHOULDER PAD**

BRACING

DX CODE (S) _____

☐ **LUMBOSACRAL ORTHOSIS (LSO) BRACE**

PRESCRIBER SIGNATURE | **DATE**

I certify that the equipment and supplies prescribed are medically necessary for this patient's care and are not provided for convenience. In my professional judgment, they are reasonable and necessary according to accepted standards of medical practice for this condition. Substitution of this device is not permitted without my written authorization.

EMAIL REFERRAL TO: teri@painraydme.com