PMT Medical Inc.

1340 Home Ave. Bldg. A
Akron, OH 44310
phone: 800-239-7880
Fax: 888-304-5454

Patient Phone: _____ DOB:_____

Patient Name: _____ Medicare #_____

Address: _____
City State Zip

Statement of Medical Necessity

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

The Hot Water Therapy Pump provides a therapeutic benefit that is not achieved solely by using a standard electric heating pad, such as increased safety, delivery of a specific temperature, and contour to treatment site. Specifically therapeutic for those who are succeptible to burns i.e. diabetics.

Patient requires: Hot water therapy pump - this modality provides localized heat therapy (moist or dry) that is safe and effective. Adjustable temperature from 30 F to 120 F (105F fixed for sensitive skin) 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 (Code E0249).

please specify body part needing therapy _____

Diagnosis: (Please circle all that apply) **HCPCS Code: E0217**

714.0 Rheumatoid Arthritis	714.89 Inflamm Polyarthrop - NEC	715.90 Osteoarthrosis NOS-Unspec
728.85 Muscle Spasm	721.3 Lumbosacral Spondylosis	724.3 Sciatica
721.90 Spondylosis NOS w/o Myelop	782.3 Edema	459.89 Poor Circulation

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

Other diagnosis: _____

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

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

Usage: _____ Hours: _____ X per day or _____ Continuous

(check skin every 20 minutes for possible adverse reaction.)

What other treatments have been tried?_____

Physician Name:_____ **UPIN#**_____ **Phone:**_____-_____

Address: _____ Fax: ( ) _____-_____
city state zip

Attending Physician Signature:_____ **Date**: _____/_____/_____
Original Signature Only - No Stamps

* physician agrees to keep chart notes on file as they pertain to this product

Consultant:_____ Consultant Phone: _____