FAX TO: 518-751-2751 (with chart notes!)

CYBERTECH & EXOS PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY FORM

(To be completed by ordering physician)

Patient Name	Work #	Home #
Address	Birth Date	
City State Zip	Gender	
Alternative Contact Relationship Phone#	City State Zip	
Physician's Full Name	Office Contact	Phone#
Practice Name	NPI#	Fax#
Address	City State Zip	

PRODUCT PRESCRIBED (Check appropriate box[es]): **ORDER DATE (REQUIRED):** ____________________

- ☐ CYBERTECH CYBERSPINE TLSO (L0464)
- ☐ CYBERTECH SI BELT (L0621)
- ☐ CYBERTECH LSO LOW PROFILE (L0641) OTS
- ☐ CYBERTECH TLSO POSTURE EXTENSION (L0457) OTS
- ☐ CYBERTECH PREMIUM PLUS (L0648) OTS
- ☐ CYBERTECH TRIMOD CHAIRBACK 8" (L0650) OTS
- ☐ CYBERTECH TRIMOD CHAIRBACK 10" (L0650) OTS
- ☐ CYBERTECH SPINE FLEX PLUS (L0642) OTS
- ☐ ASPEN VISTA TX COLLAR (L0174)
- ☐ EXOS FORM 637 (L0650) OTS
- ☐ EXOS FORM 631 (L0648) OTS
- ☐ EXOS FORM 627 (L0642) OTS
- ☐ EXOS FORM 626 (L0641) OTS
- ☐ EXOS FORM 621 (L0621)
- ☐ EXOS FORM II / EXOS FORM 637 (L0650) OTS
- ☐ EXOS FORM II / EXOS FORM 631 (L0648) OTS
- ☐ EXOS FORM II / EXOS FORM 627 (L0642) OTS
- ☐ EXOS FORM II / EXOS FORM 626 (L0641) OTS
- ☐ EXOS FORM II / EXOS FORM 621 (L0621)

Describe below why this patient requires the product indicated above and attach patient chart notes.
Medical justification must be documented in the patient's medical record.

- ☐ To reduce pain by restricting mobility of the trunk or neck
- ☐ To facilitate healing following an injury to the spine, neck or related soft tissues
- ☐ To facilitate healing following a surgical procedure on the spine or related soft tissue
- ☐ To otherwise support weak neck or spinal muscles and/or a deformed spine
- ☐ Other: ____________________

Patient Diagnosis ICD-10 Code(s) (REQUIRED): ____________________

Narrative Diagnosis: ____________________

Describe why this patient requires a back brace AND attach chart notes.
(Medical justification must be documented in chart notes.)

By my signature, I am prescribing the item listed above. In my judgment, the above-prescribed item is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

X Physician's Signature **Date**

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
☐ Workers Compensation ☐ Medicaid ☐ Non-Assigned	☐ Workers Compensation ☐ Medicaid ☐ Non-Assigned
☐ Other ____________________	☐ Other ____________________
☐ Auto Liability ☐ Medicare ☐ Assigned ☐ Insurance Card Attached	☐ Auto Liability ☐ Medicare ☐ Assigned ☐ Insurance Card Attached
Guarantor's Name / Birth Date	Guarantor's Name / Birth Date
Relation to Patient	Relation to Patient
Insurance Co. Name	Insurance Co. Name
Address	Address
City State Zip	City State Zip
Policy/ Claim No. / Subscriber / ID No.	Policy/ Claim No. / Subscriber / ID No.
Insurance Co. Phone# / Contact	Insurance Co. Phone# / Contact

SALES REPRESENTATIVE INFORMATION

Sales Representative Name Jillian Bennett, PT	Sales Representative Account # (mandatory) 561683

00-4915 Rev B

A COPY OF THIS DOCUMENT SHOULD BE RETAINED IN THE PATIENT'S MEDICAL RECORD

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