Prescription and Medical Necessity Form
EXOGEN® Ultrasound Bone Healing System
HCPCS E0760

Patient Data

First Name MI Last Name Phone# Work#

Address City/State/Zip

Date of Birth Age Sex: (M/F)

Insurance Data (please include copy of front and back of card or complete this section**)**

Primary Insurance Phone#

Policy ID# Group#

Secondary Insurance Phone#

Policy ID# Group#

The patient has the following co-morbidities (check all that apply**):**

□ Osteoporosis (M81.0) □ Long-term inhaled steroid use (Z79.51) □ Long-term systemic steroid use (Z79.52)

□ Diabetes (E11.9) □ Vascular Disease (I99.9) □ Tobacco Use (F17.200)

□ Obesity (E66.9) □ Renal Disease (N28.9) □ NSAID non-steroidal use (Z79.1)

Fracture Data

Check all that apply

□ Acute □ Non Union □ No Clinically Significant Evidence of Healing between dates of x-rays listed below

Diagnosis Code(s) (ICD-10): Fracture Gap: □ less than 1 cm

Location of Fracture:

Date of Injury: Injury due to:

Date/Type of Surgeries:

Date of X-Rays: Initial: Current:

Physician Data

Prescribing Physician NPI# Phone# Fax#

Address City/State/Zip

Dispense as written- EXOGEN Ultrasound Bone Healing System low intensity pulsed ultrasound (EO760) noninvasive therapy for 20 minutes a day. I certify that I am the treating physician and any statement on my letterhead attached hereto, has been reviewed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge.

Physician Signature: **Date / /**

Signature and Date Stamps are not acceptable