D.M.E. Prescription & Letter of Medical Necessity

EASTERN DME
MEDICAL EQUIPMENT
Phone 414.409.7646 - Fax 414.877.6068

PATIENT: _____ PHYSICIAN: _____

ACCOUNT: _____ FACILITY: _____

DIAGNOSIS: _____ DOI: _____

WC ( ) PI ( ) HI ( )

Based on our medical review and the patient's current condition, and under the Wisconsin worker's compensation statutes and treatment guidelines found under DWD 81, where it stipulates clearly outlined, the approval of durable medical equipment for a work related injury condition, it would be medically necessary at this time for the best possible outcome of the patient, to use the following home medical devices marked below:

GENERAL SUPPLIES

- ☐ Tens / EMS Unit * (R44) ☐ Rent ☐ Purchase
- ☐ Ultrasound Unit (OT1) ☐ Rent ☐ Purchase
- ☐ Paraffin Unit (AZ1) ☐ Rent ☐ Purchase

*Supplies will be needed for continuation of use.
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- ☐ Moist Heat Unit (R34)
- ☐ Home Therapy Exercise Kit (HE1)

Body Part _____

- ☐ Supplies of Electrodes and Lithium Batteries for (7) → ☐ Tens Unit or ☐ EMS Unit
- ☐ Supplies of Conductive Gel for Ultrasound (9)
- ☐ Supplies of Wax for Paraffin Bath Unit (10)

CERVICAL / UPPER EXTREMITY SUPPLIES

- ☐ Spine & Scapula Stabilizer (AM2) **Size:** S M L XL 2XL 3XL 4XL
- ☐ Cervical Traction Unit (R47) ☐ Rent ☐ Purchase

LUMBAR SUPPLIES

- ☐ Lumbar Orthosis (O22) **Size:** S M L XL 2XL 3XL 4XL
- ☐ Spine & Scapula Stabilizer (AM2) **Size:** S M L XL 2XL 3XL 4XL

LOWER EXTREMITY SUPPLIES

- ☐ Knee Orthosis (T3) ☐ Right ☐ Left
- ☐ Custom Unloader Orthosis (T7) ☐ Medial ☐ Lateral ☐ Right ☐ Left
- ☐ Custom Ligament Orthosis (T11) ☐ Medial ☐ Lateral ☐ Right ☐ Left

POST - SURGICAL SUPPLIES

- ☐ CPM Unit (M1)
  - ☐ Shoulder Left / Right
  - ☐ Knee Left / Right
  - ☐ Hand Left / Right
  - ☐ Elbow Left / Right
  - ☐ Ankle Left / Right
- ☐ RENTAL LENGTH ☐ 4 Weeks ☐ 6 Weeks ☐ 8 Weeks
- ☐ Continuous Cold / Heat / Compression Unit (R113)
  - ☐ Shoulder Left / Right
  - ☐ Hand Left / Right
  - ☐ Ankle Left / Right
  - ☐ Thoracic
- ☐ RENTAL LENGTH ☐ 4 Weeks ☐ 6 Weeks ☐ 8 Weeks
  - ☐ Knee Left / Right
  - ☐ Elbow Left / Right
  - ☐ Cervical
  - ☐ Lumbar

☐ Note: _____

Physician Signature: _____ Date: _____