PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY (CMN)

PATIENT INFORMATION:				DATE OF ORDER:	
Last Name	First Name	Middle Initial	Gender	Date of Birth	
Address		City		State	Zip Code
Phone #	Office Use:				
PRIMARY INSURANCE: Member ID:			Group #		
Secondary Insurance Company	Member ID			Group #	

PRODUCT CODE	DESCRIPTION (CHECK) RIGHT LEFT BOTH	QTY
L3916	WHFO; Wrist Hand Finger (Prefab, OTS) ____ ____ _____	____

DIAGNOSIS(es) [ICD-10]:
(Please check at least one)

- ☐ G56.00 CARPAL TUNNEL SYNDROME
- ☐ M06.9/M19.049 REUMATOID ARTH/OSTEOARTHRITIS OF HAND
- ☐ S63.90XA/S66.919A SPRAINS/STRAINS OF WRIST/HAND (UNSPECIFIED)
- ☐ ADDT'L DIAGNOSIS: ____

CERTIFICATE OF MEDICAL NECESSITY:
(Please check at least one)

- ☐ TO REDUCE PAIN BY RESTRICTING MOBILITY OF THE WRIST/HAND;
- ☐ TO FACILITATE HEALING FOLLOWING AN INJURY TO THE WRIST/HAND OR SOFT TISSUE;
- ☐ TO FACILITATE HEALING FOLLOWING A SURGICAL PROCEDURE ON THE WRIST/HAND OR SOFT TISSUE;
- ☐ TO OTHERWISE SUPPORT OR STRETCH WEAK WRIST/HAND TISSUES AND/OR DEFORMITIES

I understand that I am prescribing the above items(s), for the period(s) indicated, due to patient's needs and diagnosis(es).
I certify that the above item(s) is/are medically necessary for the patient's functional restoration: Is/are reasonable, medically necessary and not a convenience item(s): and that I am the attending physician.

Physician Name	Phone #	Fax #	
Address	City	State	Zip Code
Physician Signature	Date Signed	NPI #	

Regenesis - St. John's Medical
1704 Southside Blvd. Suite 2
Jacksonville, FL 32216
Phone: 1-904-783-9363

RETURN FAX: 1-888-430-8776 **ALTERNATIVE FAX: 904-783-0995**

PATIENT CONSULTATION SUMMARY - CHART NOTES

DATE:

PATIENT LAST NAME	PATIENT FIRST NAME	DOB	AGE	GENDER

PHYSICIAN	PATIENT CHIEF COMPLAINT	PT WEIGHT	PT HEIGHT

PATIENT HISTORY
VISIT NOTES:

ALLERGIES:

NAME	REACTION

MEDICATIONS:

NAME	CURRENT	DATE STARTED	DATE ENDED	FREQUENCY	DOSAGE

DIAGNOSIS/IMPRESSION:

PLAN:

PRESCRIBED MEDICINE:			ADDITIONAL REQUESTED DIAGNOSTICS:
NAME	DOSAGE	INSTRUCTIONS	

PHYSICIAN SIGNATURE:	DATE: