Peterson Medical
EQUIPMENT

Phone: (509) 783-7501
Fax: 1-509-980-7062

Total Pages Sent: ______ **Patient Number:** ______

NON-INVASIVE SPINE FUSION STIMULATOR — E0748
LETTER OF MEDICAL NECESSITY / STANDARD WRITTEN ORDER

PATIENT INFORMATION	ORDERING PHYSICIAN
Patient Name:	Practice Name:
Patient Phone:	Practitioner NPI:
DOB: Gender: M F	Phone:
Address:	Address:
City/State/ZIP:	City/State/ZIP:

ITEM PRESCRIBED — Mark One

- Biomet SpinalPak Non-Invasive Spine Fusion Stimulator System
- Enovis Regeneration SpinalLogic Device
- Orthofix Spinal Stimulator
- Orthofix Cervical Stimulator
- Other product (describe):
- Estimated Length (months):

SURGICAL INFORMATION

Date of Surgery:
- Primary Fusion

Prior Surgery Date:
- Repeat Fusion

Previous Fusion Date:
- Multi-Level Fusion
- Other:

Failed Fusions:

Fusion Levels:

MEDICAL HISTORY — Mark All That Apply

None	Smoker	Obesity
Osteoporosis	Rheumatoid Arthritis	Diabetes
Renal Disease	COPD	Hypertension
Steroid Use	Spondylitis (Grade 1–5)	Other

INSURANCE INFORMATION — Primary Insurance

Name of Insured:	Relation to Patient:
Insured Date of Birth:	Insurance Company:
Policy Number:	Group Number:
Address:	City / State / ZIP:
Phone:	Attach Secondary Insurance

The information on this Standard Written Order is accurate and complete to the best of my knowledge. I confirm that this patient has the condition(s) noted above and is/was being treated by me and is able to use the ordered item. The medical records substantiate the prescribed condition(s). Supporting documentation will be provided upon request for Medicare/Insurance review.

Prescriber Signature: ______________________________ Date:

Printed Name: