Renua Medical (a Health First Technologies, Inc. Company)
NeuroCare™ Medical Necessity Form

Date	Recommending Physician	Physician Phone
Patient Name (First, Middle Initial, Last	Patient Phone	Social Security #
Patient Address (including Street Address, City, State, Zip		

(Information below is to be completed by Healthcare Provider)

Location of Injury on Body: _____ _____

Diagnosis (With Diagnosis code, if known):

_____

_____

Cause of Injury: ____ Sport Injury ____ Work Injury ____ Auto , ____ Disease Related, ____ Post Surgical, ____ Other

Additional Cause of Injury Notes:

_____

_____

Claim #: _____ D.O.I: ____ / ____ / _____ (dd/mm/yyyy)

What other Therapy/Modalities have been used previously? (When and Results)

_____

What Symptoms make this Equipment Medically Necessary?

_____

How will the Patient Benefit **Therapeutically** from this Equipment?

_____

_____

____ Relaxation of muscle spasm

____ Muscle Re-education/strengthening

____ Increase local blood circulation

____ Other _____

____ Prevention of retardation of disuse atrophy

____ Maintain or increase range of motion

____ Immediate post surgical stimulation of calf muscles to prevent venous thrombosis

Recommended Type of Equipment (including Model #): _____

Length of Need: _____ Date Patient Last Seen: _____

Purchase Recommended ____ Yes ____ Rent First and purchase in two (2) months

Will Equipment be used in the patients home? ____ Yes ____ No

I, the undersigned, certify that the above-prescribed durable medical equipment is **medically necessary** as part of my treatment program for this patient. In my opinion, the equipment prescribed is reasonable and medically necessary for acceptable standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience" equipment. **Also, there should be no substitutes, if Brand Name equipment is ordered or prescribed by the Licensed Healthcare Provider.**

Date Prescribed	Ordering Healthcare Provider's Signature	Date signed