



PRESCRIPTION & LETTER OF MEDICAL NECESSITY

PATIENT NAME*

DOB*

DATE OF INJURY

DATE OF SURGERY

PRIMARY PHONE*

SECONDARY PHONE/ EMAIL



SPINAL ORTHOSIS (FILL OUT PATIENT EQUIPMENT PROTOCOL ON BACK OF PATIENT HANDOUT)

Horizon Lumbosacral Orthosis (Prefabricated) (Purchase Only)

DX Code(s) _____

The Horizon Lumbosacral Orthosis is medically necessary and prescribed to:

- reduce pain by restricting mobility of the trunk; or
- facilitate healing following an injury to the spine or related soft tissue; or
- facilitate healing following a surgical procedure on the spine or related soft tissue; or
- otherwise support weak spinal muscles and/or deformed spine.

Quantity to be Dispensed: _____ Frequency of Use: _____

Please document in patient's chart, the above checked reason(s) for prescribing and fax with Rx

PROVIDER SIGNATURE*

DATE*

PRINTED NAME*

NPI*

ADDRESS

CITY

ST.

ZIP

PHONE

FAX

I CERTIFY THAT THE EQUIPMENT AND SUPPLIES I PRESCRIBED ARE MEDICALLY NECESSARY FOR THIS PATIENT'S WELL-BEING; THIS IS NOT PRESCRIBED AS CONVENIENCE EQUIPMENT. IN MY PROFESSIONAL OPINION, THE EQUIPMENT IS BOTH REASONABLE AND NECESSARY IN REFERENCE TO THE ACCEPTED STANDARDS OF MEDICAL PRACTICE AND TREATMENT FOR THIS PATIENT'S CONDITION. SUBSTITUTION FOR THIS DEVICE IS *NOT ALLOWED WITHOUT MY WRITTEN APPROVAL*.

O- VERSION—FAX TO: (866) 318-3622

IMPORTANT GIVE TO PATIENT

HERE'S HOW TO OBTAIN YOUR PRESCRIBED MEDICAL DEVICE

Step 1

- **Zynex will call you** (usually the same day we receive your Rx!)



Step 2

- Have your medical insurance information ready



Step 3

- Zynex will ship your device directly to your home



LOOK FOR A CALL :

Zynex Medical : 303-703-4906



*If you have not heard from us within 24 hours, please call
Customer Service at (800) 495-6670.*

(SEE BACK FOR: EQUIPMENT USE)

Equipment Use Protocol

Patient Name _____

Spinal Bracing Equipment Use Protocol

Pain Management Use

Wear ____ minutes/day and increase wear time by ____ minutes every ____ day(s)

Wear spinal brace while performing the following:

Sitting Standing Walking Exercising Other _____

Instructions: _____

Post Operative Use

Day ____ thru Day ____ Wear continuously with a break of ____ minutes every ____ hour(s)

Day ____ thru Day ____ Wear continuously with a break of ____ minutes every ____ hour(s)

Wear spinal brace while performing the following:

Sitting Standing Walking Exercising Other _____

Instructions: _____