Prescription & Medical Necessity

ComforTrac Home Cervical Traction Device

Patient Name* ______________________ DOB* ______________________

Phone* ______________________ Mobile/Alternate ______________________

Name of Health Insurance* ______________________

I'm prescribing the ComforTrac Home Cervical Traction device because the patient requires greater than 20 pounds of traction for the treatment of:

ICD-10: ________________. I'm also recommending the Purchase of the cervical traction device for long-term use.

Provider Signature* ______________________ Date* ______________________

Printed Name* ______________________ NPI* ______________________

Address ______________________

City ______________________ State ____________ Zip ____________

Phone ______________________ Fax ______________________

I certify that the cervical traction I prescribed 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.*

Please Fax To: 866-791-2026 **O-Version**

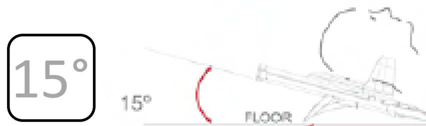
Please Fax with Patient Demographics

ComforTrac **PATIENT NAME**____________________

DEVICE SETUP

Choose the Degree of Flexion (check the box)

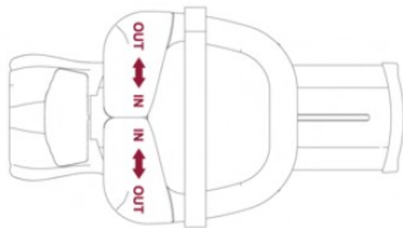
Slide stand to upper most position



Slide stand to middle position

Slide stand to lower most position

Choose the Neck Wedge Setting (check the box)



☐ Setting 1 ☐ Setting 2 ☐ Setting 3 ☐ Setting 4 ☐ Setting 5

DIRECTIONS FOR USE

☐ **Tension Type:** Sustained **Tension:** ____lbs. **Treatments/day:**____

Apply sustained tension to cervical spine with periodic rests during the ________ minute treatment time.

Additional Notes:

____

____

☐ **Tension Type:** Intermittent **Tension:** ____lbs. **Treatments/day:**____

Tension **ON** Time____Minutes and Tension **OFF** Time____Minutes

Apply intermittent tension to cervical spine per the On/OFF schedule above for the________ minute treatment time.

Additional Notes:

____

____