Rx Prescription & Letter of Medical Necessity

Patient Name*	DOB*	Date of Injury	Date of Surgery
	/ /	/ /	/ /

Primary Phone*	Secondary Phone

Spinal Orthosis (Fill Out Patient Equipment Protocol on Back of Patient Handout)

☐ Horizon Lumbosacral Orthosis (Purchase Only) **DX Code(s)** _____.____ _____.____

The Horizon Lumbosacral Orthosis is medically necessary 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.

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

*Medicare/Medicaid Insurance - **NOT ACCEPTED***

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

ZYNEX MEDICAL™

10000 Park Meadows Dr.
Lone Tree, CO 80124
Monday-Friday 8:00 AM – 4:00 PM Mountain
Customer Service: 1-855-452-0864

IMPORTANT

PLEASE READ!

HERE'S HOW TO OBTAIN YOUR PRESCRIBED MEDICAL DEVICE

1) **ZYNEX WILL CALL YOU** (USUALLY THE SAME DAY WE RECEIVE YOUR RX!)
2) HAVE YOUR MEDICAL INSURANCE INFORMATION READY
3) ZYNEX WILL SHIP YOUR DEVICE DIRECTLY TO YOUR HOME

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

IMPORTANT - GIVE TO PATIENT (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:_____

_____