Weaver MEDICAL SUPPLY

Please forward all correspondence to:

CMN (Certificate of Medical Necessity)

Weaver Medical Supply

Ph: (888) 899-8881 • Fax: (888) 606-4866 • www.weavermedical.com

Patient Name: _____ Insurance ID#: _____

Address: _____

City *State* *Zip*

Patient Phone: _____ DOB: _____ SSN #: _____

Patient Height: _____ Patient Weight: _____ *(Both are required for mobility devices)*

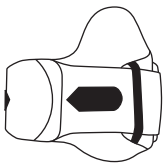
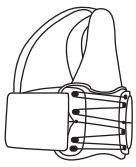
Injury/Condition/ICD10

_____

General Medical Equipment

PLEASE INDICATE:

LEFT ❑ RIGHT ❑ BOTH ❑

❑ **LSO / L0650** 	❑ **TLSO / L0457** 	❑ **THERAPY COLLAR / L0180**	❑ **ACL / L1852**	❑ **OA UNLOADER L1851**	❑ **HINGED KNEE L1833**	❑ **WRIST SPLINT L3908**	❑ **THUMB SPICA L3807**
❑ **CAM WALKER WITH AIR / L4361** HI ❑ LO ❑	❑ **LACE UP ANKLE L1902**	❑ **HINGED ANKLE L1971**	❑ **AFO L1932**	❑ **IMMOBILIZER L1830**	❑ **POST OP KNEE L1833**	❑ **ROLLATOR**	❑ **WALKER WITH WHEELS**
❑ **POWER WHEELCHAIR** * Power Mobility Evaluation Required.	❑ **WHEELCHAIR**	❑ **WHEELCHAIR ACCESSORIES** ❑ Anti-tippers (2) ❑ Back Cushion ❑ Heel Loops (2) ❑ Seat Cushion ❑ Adjustable Height Arms (2) ❑ Wheel Lock Extensions (2)		❑ **LYMPHEDEMA PUMP** ❑ Leg ❑ Arm ❑ Arm/Chest	❑ **TENS UNIT E0730**	❑ **TENS PAD REFILLS** Monthly Supply _____	❑ **TENS GARMENTS** ❑ Sock ❑ Glove ❑ Neck ❑ Thoracic ❑ Knee

❑ **OTHER PRODUCT:** _____

Instructions for use: Area of body: _____

Duration _____ Frequency _____ Order date _____ Start date _____

Provider Information

Provider Name: _____ NPI #: _____

Phone: _____ Fax: _____

Address: _____

City *State* *Zip*

I hearby certify that the following equipment is medically necessary as part of the patients treatment program. I certify that the following statements are true.

Attending Provider Signature: _____ Date: _____

(Original signature ONLY—no stamps)