PRESCRIPTION AND CERTIFICATION OF MEDICAL NECESSITY
FOR SEQUENTIAL COMPRESSION DEVICE (SCD)

PHYSICIAN: **NPI:**
ADDRESS:
CITY: **STATE:** **ZIP:**
PHONE:

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1) **PRIMARY DIAGNOSIS CODE & CPT CODES:**____
2) **MEDICAL NECESSITY**

I CERTIFY THAT THIS TREATMENT IS MEDICALLY NECESSARY FOR THE FOLLOWING REASONS:

1. FOLLOWING THEIR SURGERY, THIS PATIENT WILL HAVE LONG PERIODS OF IMMOBILITY
2. IMMOBILITY INCREASES THEIR CHANCES OF THROMBOGENESIS
3. THIS PATIENT HAS GREATER RISK OF THROMBOGENESIS DUE TO UNDERLYING CONDITIONS
4. THE SEQUENTIAL COMPRESSION DEVICE WILL DECREASE BLOOD STASIS IN THE LOWER EXTREMETIES.
5. INCREASED BLOOD FLOW THROUGH THE VENOUS SYSTEM DECREASES THE LIKELIHOOD OF THROMBOGENESIS, MINIMIZING THE RISK OF VENOUS THROMBOEMBOLISM AND EMBOLIC STROKE.

3) **MEDICARE NOTICE:** SEQUENTIAL COMPRESSION DEVICE (SCD) IS NOT COVERED FOR PATIENTS WHO ARE USING THE DEVICE TO PREVENT DEEP VEIN THROMBOSIS.

CERTIFICATE OF MEDICAL NECESSITY

SURGERY DATE____________________

PATIENT'S NAME_____________________________________ **DOB**______________________

ADDRESS:____

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CIRCLE: **STANDARD SCD** **AMBULATORY SCD**

GARMENT NEEDED: **KNEE HIGH** **THIGH HIGH** **FOOT CUFFS**

THIS RX IS GOOD FOR ONE MONTH OF USE UNLESS OTHERWISE NOTED BELOW:

2 WEEKS

2 MONTHS

OTHER (PLEASE SPECIFY):____

RECOMMENDED HOURS OF USE PER DAY:_________________________

PHYSICIAN'S SIGNATURE:__________________________________ **DATE:**___________ **TIME**________