



JAW DIVISION

# CERTIFICATE OF MEDICAL NECESSITY

Corporate Headquarters: 770 Ritchie Highway, Suite W-21 Severna Park, MD 21146  
Phone: 800.638.6771 www.dynasplint.com



Patient Name \_\_\_\_\_ (Last, First, MI)  M  F Date \_\_\_\_\_

D.O.B. \_\_\_\_\_ Date of Onset of Illness/Injury/Surgery: \_\_\_\_\_

Length of Time Needed:  3 months  6 months  9 months  Other \_\_\_\_\_

Dynasplint® Systems aid in restoring physical function to patients with joint stiffness and limited range of motion. The key to its effectiveness is the low-load, prolonged-duration stretch (LLPS) that delivers a correct biological stimulus to create a permanent length change in shortened connective tissue. Dynasplint® Systems have been clinically proven to reduce time and cost associated with range of motion rehabilitation—in many cases by more than 50 percent.

**Fill as ordered. NO substitutions:**

Jaw Dynasplint® System

**Diagnosis/Cause of Jaw (limited oral opening)**

- Arthritis of Joint (ICD-9 Code) \_\_\_\_\_
- Congenital Deformity (ICD-9 Code) \_\_\_\_\_
- Cancer of the Head & Neck (ICD-9 Code) \_\_\_\_\_
- Radiation Induced (ICD-9 Code) \_\_\_\_\_
- Neurological (ICD-9 Code) \_\_\_\_\_
- Trauma (accident, surgery, etc.) (ICD-9 Code) \_\_\_\_\_
- Surgery (ICD-9 Code) \_\_\_\_\_
- Other: \_\_\_\_\_ (ICD-9 Code) \_\_\_\_\_

**Current oral opening Range of Motion:** (Active/Passive) \_\_\_\_\_ / \_\_\_\_\_ mm (Adult Average is 45-50mm)

IS THE PATIENT CURRENTLY INVOLVED IN ANY THERAPY PROGRAM?  Yes  No

Physician Name: \_\_\_\_\_

N.P.I.#: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Attending Therapist: \_\_\_\_\_

**FAX TO:**

This form is needed to bill the patient's insurance. Please complete and return.

\_\_\_\_\_  
SALES CONSULTANT

\_\_\_\_\_  
PHONE

\_\_\_\_\_  
e-FAX