



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