

Certificate of Medical Necessity

Continuous Passive Motion (CPM) Device – E0935

Section A		Certification Type & Date: _____ Initial CMN Date ____/____/____ Revised CMN Date ____/____/____	
Patient Name Patient Address City-State-Zip Phone Number	Supplier Information JACE SYSTEMS 5 Rockhill Road Ste.2 Cherry Hill, NJ 08034 800-800-4276		
Social Security Number	Patient DOB ____/____/____ Sex: M F		
Place of Service (If other than patient's home)	Physician Name Physician Address City-State-Zip Phone Number UPIN		
Territory #			

Section B Information in this section may not be completed by the provider of service.

1 Description of Procedure(s): _____		Diagnosis Codes (ICD9): _____	
2	____/____/____ ____/____/____	Provide the date of surgery (when applicable)	
		Provide the date of initial post operative application of CPM	
3	➔ Circle Y, N, or D for each justification point as Y=Yes N=No D=Does not Apply		
Y N D Y N D Y N D Y N D Y N D Y N D Y N D	Increase and maintenance of range of motion Prevention of adhesion formation Avoidance of additional surgery secondary to adhesions Reduction or avoidance of hospital stay Reduction of post-operative pain medication(s) Reduction of overall rehabilitation time Reduction of post-operative edema		
4 Additional Justification (Narrative)	_____ _____ _____		

Section C Prescriptive Information for CPM Application

Please Complete	Indicate ROM goal: <input type="checkbox"/> Full ROM of: _____ <input type="checkbox"/> Limited ROM of: _____		
Parameters :	Estimated Length of Need: _____ Weeks Specific Device (optional) _____		
	Motion _____ Range _____ Hrs/Day _____		
	Motion _____ Range _____ Hrs/Day _____		
	Advancement Limits _____ per hour/day/week (circle one) Not to exceed _____		
Y N D	Use of Brace during CPM session _____ If yes, Brace Settings _____		

Section D Physician Attestation and Signature / Date

By my signature below I certify I am the prescribing physician listed above and have reviewed this form and attachments hereto and that the information herein is true, accurate and complete to the best of my knowledge.

 Prescribing Physician's Signature

 Date of Signature