Send signed Rx along with patient demographics & most recent office note to **neworders@gatewaymedical.net** or fax to: (636) 489-1564

RX, Pre-Auth & Medical Necessity Certification

Patient Name:_____ DOB:_____

Rx: E0747 CMF OL1000 Osteogenesis Stimulator, electrical, non-invasive, non-spinal applications

Diagnosis:

☐ Nonunion Fracture ☐ Failed Joint Fusion ☐ Other_____

Location:	**Type:**	**Additional Risk Factors:**	
☐ Prox	☐ Open	☐ Alcohol Use	☐ Obesity
☐ Distal	☐ Closed	☐ Osteoporosis	☐ Arthritis
☐ Left		☐ AVN	☐ Osteomyelitis
☐ Right		☐ Diabetes	☐ Tobacco Use
☐ Bilateral		☐ Comminuted Fracture	☐

Bone Site:

☐ Tibia	☐ Medial Malleolus (Tibia)	☐ Metacarpal 1 2 3 4 5	☐ Phalanges (Finger) 1 2 3 4 5
☐ Fibula	☐ Lateral Malleolus (Fibula)	☐ Metatarsal 1 2 3 4 5	☐ Phalanges (Toe) 1 2 3 4 5
☐ Tibia/Fibula	☐ Ulna	☐ Humerus	☐ Radius
☐ Femur	☐ Scaphoid (Navicular in Wrist)	☐ Clavicle	Other: _____

Date of Surgery: _____ / _____ / _____

Prior Surgical Procedures:_____ **Date:** _____ / _____ / _____

☐ Osteotomy	☐ Internal Fixation	☐ IM Rod	☐ Cast
☐ Bone Graft	☐ Screws	☐ Wire	☐ Fixator Removal
☐ Debridement	☐ Plate	☐ External Fixation	☐ Other _____

☐ Both an osteotomy and joint fusion were performed. The specific healing status of each one is noted below. Fracture status and site specifically identified in the diagnostic interpretation as summarized below.

☐ I am trained to interpret the x-rays. The x-ray interpretations are noted in my progress notes and summarized below.

Date of 1st diagnostic test and description of fracture or fusion:_____

_____

Date of last diagnostic test and description of fracture or fusion status:_____

_____

The information with the box checked describes the patient's fracture gap:

☐ This is a fracture that does not have a measurable gap.

☐ Fracture gap les than 1cm. How many mm? _____(10mm equals 1cm)

☐ Fracture site was adequately immobilized, and patient was able to comply with non-weight bearing requirements

Reason why patient is not a good candidate for surgery:_____

_____

Other conservative measures:_____

Date of Service: _____ / _____ / _____ **Length of Treatment:** _____ (number of months) **Not Placed:** _____

My signature below means that, in my judgement, the above-prescribed item is medically indicated and necessary, and consistent with current accepted standards of medical practice and treatment of this patient's physical condition. My signature also serves to confirm the veracity of all information included in this document.

Physician's Signature:_____ Printed:_____

NPI:_____ Date:_____