ADVANCED RECOVERY SPECIALISTS

PRESCRIBER'S PRESCRIPTION

INTERMITTENT COLD & COMPRESSION THERAPY

Rx

CONTACT INFORMATION:

PLEASE FAX OR EMAIL COMPLETED FORM TO:

Fax: **248.487.9442** Email: **sales@advancedrecover.com**

FOR BILLING QUESTIONS, PLEASE CALL: **573.214.2061 (EXT. 1077)**

FOR INQUIRIES, PLEASE CALL: **248.499.0705**

PATIENT:

Patient Name: ❑ **Surgical** ❑ **Non-Surgical**

ICD-10 Code:

Product: Intermittent Cold & Compression Therapy Device **Sx Date:**

Duration:	☐ 1 Month	☐ _____ months	
Orientation:	☐ Left	☐ Right	☐ N/A

PRESCRIPTION INFORMATION:

Cold and Compression Wrap:

☐ Back	☐ Knee	☐ Hip	☐ Foot / Ankle
☐ Neck	☐ Shoulder	☐ Hand / Wrist	☐ Elbow

PRESCRIBER INFORMATION:

Dispense As Written (DAW), Do Not Substitute: I am prescribing my patient an intermittent cold and compression therapy device. I have chosen this device because of the specific clinical efficacy, functionality and feature set. Other intermittent cold and compression therapy devices do not deliver the same clinical efficacy and treatment options for my patient. As a result dispense as written my prescription for this patient and do not substitute this order for my patient.

Prescriber Signature: **Date:**

Prescriber Printed Name: **NPI:**

Address:

City: **State:** **Zip:**