ADVANCED RECOVERY SPECIALISTS

PRESCRIBER'S PRESCRIPTION
ONLUX LLLT AND PHOTOBIOMODULATION

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: OnLux LLLT and Photobiomodulation **Sx Date:**

Duration:	☐ 3 Months	☐ _____ months	
Orientation:	☐ Left	☐ Right	☐ N/A

PRESCRIPTION INFORMATION:

Cold and Compression Wrap:

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

PRESCRIBER INFORMATION:

Physician's letter of medical necessity: I am writing on the behalf of my patient that you approve coverage for the OnLux device, delivering LLLT operative treatment. The OnLux device utilizes a combination of three different RED light and near-infrared light wavelengths to relax muscles, improve circulation, decrease inflammation that causes pain, and expedites the tissue repair and healing process. It has been clinically proven to reduce pain and swelling and provide lasting relief without use of pain medication through safe clinically proven therapy. My treatment and rehabilitation care plan call for the use of this device to promote bloodflow and enhance cellular healing via revascularization of tissue, and return to work properly. I certify the OnLux device is medically indicated and, in my opinion, is reasonable and necessary.

Prescriber Signature: **Date:**

Prescriber Printed Name: **NPI:**

Address:

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