Letter of Medical Necessity

Patient Name:_____ Date of Birth:_____

ID#: _____ Claim #:_____

Payor Name: _____

Bone Growth Stimulator Medical Necessity Summary

Date of Injury: _____ ICD9 Codes: _____

Diagnoses: ☐ Multi Level Spinal Fusion ☐ Failed Spinal Fusion ☐ Single Level Fusion With Risk Factors

Other: _____

Primary Diagnosis

☐ Degenerative Disc Disease ☐ Sclerosis ☐ Herniated Nucleous Pulposus

☐ Internal Disc Disruption ☐ Lumbar Instability ☐ Spondylolisthesis/ Grade

☐ Low Back Pain ☐ Radiculopathy ☐ Spinal Stenosis

☐ Other: _____

Planned Procedure:

Date of Surgery: Fusion Levels: to

Other: _____

Prior Surgical Procedure(s)

☐ Fusion Surgery	Date:	Levels:	to
☐ Disectomy	Date:	Levels:	to
☐ Laminectomy	Date:	Levels:	to
☐ Other	Date:	Levels:	to

All That Apply Are Checked :

☐ Multi Level Fusion	☐ Alcohol use	☐ Obesity
☐ Mixed Graft	☐ Osteoporosis	☐ Arthritis
☐ Allograft	☐ Osteomyletis	☐ Tobacco Use (ppd)
☐ Autograft	☐ Failed Fusion	☐ Spondylolisthesis
☐ AVN	☐ Diabetes	☐ Stenosis
☐ Previous Back Surgery	☐ Other : _____	

DOS: _____ Length of Treatment: _____ (number of months) Not Placed: _____

Physician Name: _____

Physician Address: _____

My signature below means that, in my judgment, 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 Signature: _____ Date: