CERVICAL TRACTION DEVICE
PRESCRIPTION AND LETTER OF MEDICAL NECESSITY

Patient Name _____

Date of Birth _____

Cervical traction unit ordered**:** _____ Saunders Cervical Traction Unit (E0849)
_____ Comfor Trac Cervical Traction Unit (E0849)

Duration: _____ Purchase OR _____ Rental for #_____ months

Diagnosis**:** _____

ICD Codes**:** _____

The following information is required in order to justify the use of the above prescribed cervical traction unit.

1. Does this patient have a musculoskeletal or neurological impairment requiring traction equipment? Yes No

2. Does this patient require a traction unit capable of generating greater than 20 pounds of Traction that is to be used in the home? Yes No

3. Does this patient have a diagnosis of TMJ dysfunction and has this patient received Treatment for the TMJ condition? Yes No

4. Does this patient have distortion of the lower jaw or neck anatomy such that a chin halter is not able to be utilized? Yes No

5. Has the appropriate use of the cervical traction unit been demonstrated to this patient? Did the patient tolerate the device? Yes No

Physician's Signature _____Date_____

Physician's Name _____

NPI #_____ UPIN #_____

Address _____

City/State/Zip_____

FAX THIS COMPLETED FORM TO GOLDEN STATE MEDICAL, INC. AT (530) 885-3631