Fax or Email:
424-293-1283
rx@mamastrut.com

Certificate of Medical Necessity

Total Pelvic Double Truss System

MamaStrut™ by PELV-ICE

Patient Due Date : _____

Patient Info

First : _____ **M :** _____ **Last :** _____
DOB : _____ **Sex :** ☐ **Male** ☐ **Female**
Address : _____
City : _____ **State :** _____ **Zip :** _____
Phone : _____ **Email :** _____

Patient Insurance Info

Primary Insurer : _____
Policy : _____
ID number : _____
Group # : _____
Phone : _____
Secondary Insurer : _____
Policy : _____
ID number : _____
Group # : _____
Phone : _____

Product Description

Double truss with standard pads, 8" wide medical grade, latex free, anti-microbial abdominal, pelvic-sacral and lumbar support secured by attached compression shorts with 3 attached and adjustable pelvic floor/perineum/hernia elastic tension straps. Removable pouches with gel packs for cryotherapy or heat therapy, in combination with compression to reduce pain, swelling and pressure for the lumbar, hips abdomen and perineum.

For sizing, reference sizing guide at www.mamastrut.com/sizing-care

Provider Info

Prescribing Provider Name : _____
Clinic Name : _____
Street Address : _____
City : _____ **State :** _____ **Zip :** _____
Email : _____
Phone : _____ **Fax :** _____

Please ensure # is correct as we will be faxing/calling this number

Diagnosis

DOI : _____ (same as signing date)

Duration of Need :

☐ **3 Months** ☐ **6 Months** ☐ **99 Months** ☐ **Other:** _____

- ☐ R10.2 Pelvic and perineal pain
- ☐ R10.30 Lower Abdominal, inguinal, groin pain
- ☐ 071.89 Other specified obtetric trauma (Diastasis Recti)
- ☐ M54.5 Acute or chronic pain in the lumbar or sacral regions
- ☐ M25.551/M25.552 Hip Pain R/L
- ☐ Other: _____

Device

- ☐ Postpartum Pelvic Double Truss System
- ☐ During Pregnancy Pelvic Double Truss System
- ☐ I'm interested in getting a breast pump through insurance

Supporting Clinical Notes (Required)

I certify that I am the physician/practitioner identified on this form. I have reviewed the Certificate of Medical Necessity. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and physician notes and other supporting documentation will be provided upon request. I understand any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Provider Signature : _____ **Date :** _____

Printed Name : _____ **NPI :** _____