

# Certificate of Medical Necessity

## Total Pelvic Double Truss System



Patient Due Date: \_\_\_\_\_

**This Entire Document Must Be Completed Before Submitting for Insurance**

**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](http://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 : \_\_\_\_\_

This fax message and any attachments may contain confidential information. If you are not the intended recipient and have received this message in error, please inform sender and delete the contents without copying, distributing or forwarding. By faxing this form you are acknowledging that the patient is aware that a representative may be contacting them for any additional information to process this order. Thank you.