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

Certificate of Medical Necessity

Lower Extremity Control Sling

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

Multi-function medical grade pelvic, hip, abdominal & lower back control sling used as a supportive recovery device, hernia truss & lower extremity support brace. Adjustable triple padded under-truss straps, removable pouches with gel packs for cryo and heat therapy at the back, perineum and/or abdominals, adjustable compression, built in compression shorts, latex free and anti-microbial.

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
- ☐ N81.4 UteroVaginal Prolapse, unspecified
- ☐ Other _____

Device

- ☐ Lower Extremity Control Sling (Postpartum)
- ☐ Low Profile Lower Extremity Control Sling (Pregnancy)
- ☐ 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 :** _____