Fax or Email:
(424) 293- 1283
Rx@mamastrut.com

Certificate of Medical Necessity

Total Pelvic Support System

MamaStrut™ by PELV-ICE

Due Date: ____/____/____ **Start Date:** ____/____/____

(MUST BE THE SAME AS THE PROVIDER SIGNATURE DATE BELOW)

Patient Info

First:_____ **Last:**_____ **MI:**____ **Patient DOB:**____/____/____ **Sex:** ☐ M ☐ F

Address:_____ **Phone #:**_____

City:_____ **State:**_____ **ZIP:**_____ **E-mail Address:**_____

Diagnosis

- ☐ R10.2 Pelvic and perineal pain
- ☐ R10.30 Lower Abdominal, inguinal, groin pain
- ☐ 071.89 Other specified obstetric trauma (Diastasis Recti)
- ☐ M54.5 Acute or chronic pain in the lumbar or sacral regions
- ☐ M25.551/M25.552 Hip pain R/L
- ☐ S30.23 Contusion of vagina and vulva
- ☐ K42 Umbilical hernia

O70 Perineal laceration during delivery:

- ☐ O70.0 First degree perineal laceration during delivery
- ☐ O70.1 Second degree perineal laceration during delivery
- ☐ O70.2 Third degree perineal laceration during delivery
- ☐ O70.3 Fourth degree perineal laceration during delivery
- ☐ O70.4 Anal sphincter tear complicating delivery, not associated with third degree laceration

N81 Female genital prolapse:

- ☐ N81.2 Incomplete uterovaginal prolapse
- ☐ N81.3 Complete uterovaginal prolapse
- ☐ N81.4 Uterovaginal prolapse, unspecified

N81.8 Other female genital prolapse:

- ☐ N81.83 Incompetence or weakening of rectovaginal tissue
- ☐ Other: _____

Duration of Need: _____months
(99 = Lifetime)

Answer All Questions Below

**Questions regarding a previous delivery must be answered accordingly for all patients, including first-time moms.*

- ☐**yes** ☐**no** Does the patient suffer from pelvic floor dysfunction or incontinence?
- ☐**yes** ☐**no** Did the patient suffer with recurrent/persistent low back pain with this pregnancy?
- ☐**yes** ☐**no** Does the patient have genital prolapse?
- ☐**yes** ☐**no** Does the patient have a history of hemorrhoids?
- ☐**yes** ☐**no** Does the patient have a BMI over 30 with an increased wound infection risk?
- ☐**yes** ☐**no** Does the patient have severe diabetes and a history/or increased risk for wound infections, slow healing wounds?
- ☐**yes** ☐**no** *Did the patient have a 3rd or 4th degree vaginal tear with a previous delivery?
- ☐**yes** ☐**no** *Did the patient have a breakdown of the suture, opening of skin with infection in a previous delivery?
- ☐**yes** ☐**no** *Did the patient have an episiotomy with a previous delivery?
- ☐**yes** ☐**no** *Did the patient have a rectal fissure repaired after a previous delivery?
- ☐**yes** ☐**no** *Did the patient have a prolonged recovery from a vaginal tear in a previous delivery?
- ☐**yes** ☐**no** *Did the patient have a prior c-section with wound infection and/or wound disruption?
- ☐**yes** ☐**no** *Does the patient have diastasis or hernia from a prior c-section or vaginal delivery?

Insurance

Primary Insurance: _____
Policy/ID #: _____
Group #: _____
Phone #: _____

Secondary Insurance: _____
Policy/ID #: _____
Group #: _____
Phone #: _____

Provider Info

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

Mama Strut Postpartum Care System

Select Size:

Measure below the belly around the pelvis/hips.

XS | S | M | L | XL | 2XL | 3XL | 4XL

Size	Fits Postpartum Size	Size	Fits Postpartum Size
XS	29" to 34" (73cm to 87cm)	XL	42" to 48" (107cm to 123cm)
S	32" to 37" (82cm to 94cm)	2XL	48" to 54" (122cm to 137cm)
MED	35" to 42" (94cm to 107cm)	3XL	54" to 60" (137cm to 152cm)
LG	38" to 45" (97cm to 115cm)	4XL	60" to 64" (152cm to 163cm)

Product Description:

Postpartum/Post-op: 8" wide medical grade quality, latex free, anti-microbial abdominal, pelvic-sacral and lumbar support secured by attached compression shorts for maximum stability with 3 attached and adjustable pelvic floor/perineum/hernia elastic tension straps. Use with or without adjustable tension straps to customize placement and amount of support.
Removable and adjustable pouch 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. Latex free.

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: _____
(STAMPS NOT ACCEPTABLE)

NPI#: _____