

Patient Device Fax Order Form

FAX number : (800) 889-9054

Date _____ # of pages _____

Clinic Name: _____ Empi Clinic # _____

Ship attention to: _____ Date needed _____

Deliver to Clinic

Deliver to Patient Home: (attach AOB/LOMN)

Clinic Contact _____ Clinic phone: _____

Instructions:

1. Select Device
2. Attach copy of patient information

3. If shipping to patient home, include AOB/Rx form signed by patient and MD
4. Fax to (800) 889-9054

- Empi TENS
- Low Back Garment
- IF 3WAVE® IF
- 300PV® Choose [circle] NMES HIGH VOLT
- INFINITY™ [IFC]
- SporTX PDC
- NT 2000 NMES

- Saunders Cervical HomeTrac® Traction
- Saunders Lumbar Traction
- Pronex Cervical traction
Choose Size [circle] Regular/Large/Wide
- Minnova®
- Advance® Dynamic Range of Motion Splint
Joint: _____
Motion: ___ Flexion ___ Extension

Additional Comments

___ Insurance information attached
___ Prescription attached

___ Prescription at clinic to be sent with
Rental Sales Agreement

Please complete patient information below OR fax patient intake/cover sheet from chart.

*Insurance information must be included [copy of card if private insurance].

Claim Type: WC Private Medicare Medicaid

Patient name _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

DOB: _____ SS #: _____

Insurance Company: _____

Insurance Address: _____

Insurance Phone _____

Policy/Claim #: _____ Group #: _____

Policy Holder's name: _____

Date of Injury: _____

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