LETTER OF MEDICAL NECESSITY

Instructions for Healthcare Provider

This form is intended to assist licensed healthcare providers in documenting the medical necessity of recovery services provided by Recover Cryo. Please complete all applicable sections. Incomplete forms may delay the client's ability to utilize this documentation for reimbursement or other purposes.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Home Address: _____

City: _____

State: _____

ZIP Code: _____

TREATING HEALTHCARE PROVIDER

Provider Name: _____

Medical Practice / Clinic: _____

Professional Title: _____

Medical Specialty: _____

Practice Address: _____

Office Phone: _____

Office Email: _____

NPI Number: _____

State License Number: _____

PATIENT DIAGNOSIS

Primary Diagnosis

ICD-10 Diagnosis Code(s) (if applicable)

Date of Diagnosis

CLINICAL FINDINGS

Please describe the patient's condition, symptoms, physical limitations, and clinical findings that support the requested recovery services.

PREVIOUS TREATMENT HISTORY

Please indicate which treatments have been attempted.

☐ Physical Therapy
☐ Occupational Therapy
☐ Chiropractic Care
☐ Massage Therapy
☐ Medication Management
☐ Orthopedic Care
☐ Sports Medicine
☐ Exercise Rehabilitation
☐ Surgery
☐ Other

Please describe the patient's response to previous treatment.

FUNCTIONAL LIMITATIONS

Please identify the patient's current functional limitations.

☐ Pain during daily activities
☐ Reduced range of motion
☐ Muscle tightness

☐ Muscle weakness
☐ Chronic inflammation
☐ Decreased flexibility
☐ Difficulty walking
☐ Difficulty exercising
☐ Impaired athletic performance
☐ Delayed recovery after activity
☐ Post-operative recovery
☐ Other

REQUESTED RECOVERY SERVICES

Based upon my professional medical judgment, I recommend the following services:

☐ Localized Cryotherapy
☐ Compression Therapy
☐ Assisted Stretch Therapy
☐ Combination Therapy

MEDICAL NECESSITY

In my professional medical opinion, the above services are medically appropriate because:

☐ Pain management
☐ Reduction of inflammation
☐ Improve circulation
☐ Improve mobility
☐ Improve flexibility
☐ Improve athletic recovery
☐ Improve functional movement
☐ Assist post-surgical recovery
☐ Assist injury rehabilitation
☐ Reduce muscle soreness
☐ Other

Please explain your recommendation.

RECOVER CRYO
CRYOTHERAPY

TREATMENT RECOMMENDATION

Recommended Frequency

_____ sessions per week

Recommended Duration

_____ weeks

Estimated Total Sessions

Special Instructions

PROVIDER CERTIFICATION

I certify that I am a licensed healthcare provider legally authorized to diagnose and treat the patient identified in this document.

Based upon my examination, medical records, and professional judgment, I believe the recovery services recommended above are medically appropriate for this patient and may assist in supporting their recovery, rehabilitation, pain management, mobility, or overall physical function.

I understand that this recommendation does not guarantee insurance reimbursement or payment and is intended solely to document my professional medical opinion regarding the patient's current condition.

HEALTHCARE PROVIDER SIGNATURE

Provider Name (Print):

Professional Credentials

Provider Signature

Date

Practice Stamp (if applicable)

CLIENT ACKNOWLEDGEMENT

I understand that this Letter of Medical Necessity is intended solely as documentation from my treating healthcare provider and does not guarantee reimbursement, insurance coverage, approval of services, or any specific treatment outcome.

I understand that Recover Cryo will rely upon the information provided by my healthcare provider when appropriate but does not replace or assume responsibility for ongoing medical care.

Client Signature

Date

RECOVER CRYO OFFICE USE ONLY

Date Received

Received By

Recommended Services Entered

☐ Yes

☐ No

Additional Notes