

Section 1: PATIENT (To be completed by the patient)

Name:	
Mailing Address:	
Name of Insurance Provider:	
Subscriber's ID#:	
Date of Birth:	

Section 2: DIAGNOSIS (To be completed by the physician)

Migraine 346.___ __

Choose the appropriate 4th digit

346.0_	Migraine with aura
346.1_	Migraine without aura
346.2_	Variants of migraine, not elsewhere classified
346.3_	Hemiplegic migraine
346.4_	Menstrual migraine
346.5_	Persistent migraine aura without cerebral infarction
346.6_	Persistent migraine aura with cerebral infarction
346.7_	Chronic migraine without aura
346.8_	Other forms of migraine
346.9_	Migraine, unspecified

Choose the appropriate 5th digit:

346._0	Without mention of intractable migraine w/o mention of status migrainosus.
346._1	With intractable migraine, so stated, w/o mention of status migrainosus
346._2	Without mention of intractable migraine with status migrainosus
346._3	With intractable migraine, so stated, with status migrainosus

Other Clinical Considerations include, but are not limited to:

<input type="checkbox"/> 307.81 - Tension Headache	<input type="checkbox"/> 473.9 - Chronic Sinusitis
<input type="checkbox"/> 333.82 - Orofacial Dyskinesia	<input type="checkbox"/> 478.0 - Turbinate Hypertrophy
<input type="checkbox"/> 333.83 - Spasmodic Torticollis	<input type="checkbox"/> 722.4 - Degeneration of cervical disc
<input type="checkbox"/> 350.1 - Trigeminal Neuralgia	<input type="checkbox"/> 723.1 - Cervicalgia
<input type="checkbox"/> Other _____	

Section 3: MEDICAL NECESSITY

Frequency of pain episodes per week:	
Severity of Pain (Scale of 1-5) (5 as intolerable):	
Significant Findings on Physical Examination:	
Significant Findings on Labs or Diagnostic Exams:	
Current Prescriptions for Pain (Please list):	
Adverse events or intolerance to pain medications:	
Other contraindications:	

Section 4: RECOMMENDATION for E0217-NU Water Circulating Heat Pad with Pump

Based upon this patient's chief complaint, history and physical exam related to frequency and severity, the following items are being prescribed:

- E0217 - SootheAway Continuous Thermal Therapy Device (003-01)
- E0249 – Front & Side Head Relief Pad (003-10)
- E0249 – Rear Head (Occipital) Relief Pad (003-11)
- E0249 – Eye Relief Pad (003-12)
- E0249 – Universal Relief Pad (003-13)

For additional information, evidence of medical necessity and/or Peer-to-Peer discussion regarding this patient's need for the SootheAway Thermal Treatment System, please do not hesitate to contact me.

Physician Name:		
Address:		
Phone:		
Fax:		
NPI:		
Signature:		Date: