LETTER OF MEDICAL NECESSITY

RE: Certificate of Medical Necessity (CMN)

Patient Name:		DATE:	
Medical Record Number:			

Prescription for the "Back Bubble" pelvic traction device.
HICFA Code# "E0947NU" Complex pelvic traction

Diagnostic treatment code:	

Dear Sir/Madam,

I have prescribed the purchase of the Back Bubble complex pelvic traction modality for my patient, . The Back Bubble decompresses spinal column and provides relief from intractable lower back pain caused by .

The Back Bubble also allows my patient to perform strengthening as well as joint and muscle flexibility exercises while under traction.

It is my recommendation that the Back Bubble will minimize costly physical therapy treatments and the possibility of surgery. My patient will have the ability to relieve his/her lower back pain at home.

The Back Bubble, along with his/her home therapy program, will help ensure recovery.

I recommend no substitute pelvic traction other than the Back Bubble for my patient. The Back Bubble can only be obtained through the manufacturer ''Back Bubble."
Please let me know if you require further information or have any questions.

Sincerely,

Physician's Signature:	
Physician's Name:	