

PLEASE COMPLETE AND RETURN TO ATOS MEDICAL • 2801 SOUTH MOORLAND ROAD • NEW BERLIN, WI 53151 • TEL 800.217.0025 • FAX 844.389.4918

PATIENT INFO	PATIENT FIRST NAME*	MI	PATIENT LAST NAME*	DATE OF BIRTH (MM/DD/YYYY)*	
	STREET*		CITY*	ST*	ZIP*
	PATIENT TELEPHONE		PATIENT EMAIL		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	<div style="background-color: red; color: white; padding: 5px; font-weight: bold;"> IMPORTANT: TO ASSIGN AN AUTHORIZED REPRESENTATIVE TO COMMUNICATE WITH ATOS ON YOUR BEHALF, COMPLETE HERE </div>		AUTH REP NAME	AUTH REP TELEPHONE	AUTH REP EMAIL

PRESCRIPTION INFO	JAW MOBILITY SUPPLIES			
	THERABITE JAW MOTION REHABILITATION SYSTEM		QTY	OTHER
	<input type="checkbox"/> TheraBite Jaw Motion Rehabilitation System, Adult [E1700]		1	_____
	<input type="checkbox"/> TheraBite Jaw Motion Rehabilitation System, Pediatric [E1700]		1	_____
	THERABITE BITE PADS		QTY	OTHER
	<input type="checkbox"/> TheraBite Bite Pad, Regular [E1701]		1/month	_____
<input type="checkbox"/> TheraBite Bite Pad, Pediatric [E1701]		1/month	_____	
<input type="checkbox"/> TheraBite Bite Pad, Edentulous [E1701]		1/month	_____	

PHYSICIAN/CLINICIAN USE ONLY	ENTER ICD-10 CODE – REQUIRED FOR MEDICARE				
	DIAGNOSIS CODE* (CHOOSE ONE)			RX VALID 12 MONTHS FROM DATE	
	<input type="checkbox"/> Z92.3 Personal history of irradiation <input type="checkbox"/> M26.52 Limited mandibular range of motion <input type="checkbox"/> M26.53 Deviation in opening and closing of the mandible <input type="checkbox"/> _____			Indicate ONLY If Less _____	
	CLINICIAN NAME		CLINICIAN TELEPHONE	CLINICIAN EMAIL	
	NOTES PLEASE SEND COPIES OF CLINICAL NOTES WITH ANY PRESCRIPTION				
	FACILITY NAME AND ADDRESS		PHYSICIAN EMAIL	PHYSICIAN TELEPHONE	PHYSICIAN FAX
			PHYSICIAN/PRACTITIONER NAME*	PHYSICIAN/PRACTITIONER NPI*	
		PHYSICIAN/PRACTITIONER SIGNATURE* NO STAMPS ALLOWED	DATE/START DATE*		
I certify the medical necessity of these items including any accessories for this patient. This section of the form and any statement on my letterhead attached here has been completed by me or by my employee(s) and reviewed by me. The foregoing information is true, accurate and complete and any falsification or omission of material fact may subject me to civil or criminal liability.					

GUIDANCE FOR COMPLETING A VALID PRESCRIPTION	
<p>CLINICAL NOTES Clinical notes are REQUIRED for insurance reimbursement. Submit annually with RX form.</p> <p>PHYSICIAN DETAILS Signature MUST match prescriber name/NPI#. No stamps allowed. Clinician may not sign RX per Medicare and insurance guidelines.</p>	<p>OTHER IMPORTANT NOTES</p> <ul style="list-style-type: none"> No NEW or REPLACEMENT items may be added to an existing, signed RX. A new RX must be completed instead. If a correction is needed while completing an RX by hand, use a SINGLE STRIKE-THROUGH, intital and date. Do not use white out, black out, scribble out text, modify or reshape letters or numbers.