Atos

PRESCRIPTION FORM
For Jaw Mobility Supplies

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	☐ MALE ☐ FEMALE

IMPORTANT: TO ASSIGN AN AUTHORIZED REPRESENTATIVE TO COMMUNICATE WITH ATOS ON YOUR BEHALF, COMPLETE HERE

AUTH REP NAME	AUTH REP TELEPHONE	AUTH REP EMAIL

PRESCRIPTION INFO

JAW MOBILITY SUPPLIES		
THERABITE JAW MOTION REHABILITATION SYSTEM	**QTY**	**OTHER**
☐ TheraBite Jaw Motion Rehabilitation System, Adult [E1700]	1	_____
☐ TheraBite Jaw Motion Rehabilitation System, Pediatric [E1700]	1	_____
THERABITE BITE PADS	**QTY**	**OTHER**
☐ TheraBite Bite Pad, Regular [E1701]	1/month	_____
☐ TheraBite Bite Pad, Pediatric [E1701]	1/month	_____
☐ TheraBite Bite Pad, Edentulous [E1701]	1/month	_____

PHYSICIAN/CLINICIAN USE ONLY

ENTER ICD-10 CODE – REQUIRED FOR MEDICARE

DIAGNOSIS CODE* (CHOOSE ONE)
☐ Z92.3 Personal history of irradiation ☐ M26.52 Limited mandibular range of motion
☐ M26.53 Deviation in opening and closing of the mandible ☐ _____

RX VALID 12 MONTHS FROM DATE
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

CLINICAL NOTES
Clinical notes are REQUIRED for insurance reimbursement.
Submit annually with RX form.

PHYSICIAN DETAILS
Signature MUST match prescriber name/NPI#. No stamps allowed.
Clinician may not sign RX per Medicare and insurance guidelines.

OTHER IMPORTANT NOTES
- 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, intitial and date. Do not use white out, black out, scribble out text, modify or reshape letters or numbers.

This is a prescription form only and will NOT automatically generate an order for shipment

*Required