



PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name

Date of Birth

PRESCRIBED EQUIPMENT

E0190 "Restore You" Therapeutic Support

LETTER OF MEDICAL NECESSITY

It is crucial for physicians to develop a personalized care strategy that suits the unique needs and medical history of each patient. The primary aim is to mitigate pain, promote restorative sleep, and accelerate the recovery process, allowing patients to return to their normal daily routines. There is a growing trend among physicians to embrace a holistic healing approach, seeking to diminish dependence on addictive pain medications and ultimately diminishing the need for interventions in pain management.

My plan of care for this patient calls for the Restore You Therapeutic Support to reduce pain and facilitate sleep while decreasing the patient's healing time. I certify that the device I am prescribing is medically necessary to treat the specific medical condition my patient is experiencing and is not for general good health or cosmetic purposes.

I also certify that the device will assist individuals to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

Physician Name

Physician NPI

Physician Phone

Date

Physician Signature