Medical Certificate of Need

Date:	Name of Insurance Company:	
Address:		
City:	State:	Zip:

Re: Letter of Medical Certificate of Need for the Universal Vests (UVests/Pro Series/UKV)

Patient Name:	
Group/Policy Number:	Diagnosis Code:

○ Compression/Stability ○ Spine Stabilization ○ Thoracic Stabilization ○ Trunk Control/Posture

○ Back/Sacral Pain ○ Lifts/Transfers ○ Gait Training ○ Other_____

Universal Vests (UVests/Pro Series/UKV) Needed:

○ Universal Vests (UVests) Commercial ○ UVests Pro Series #_____ ○ Universal Kyphotic Vests

This letter serves to document that _____ has a diagnosis of _____ and requires the utilization of the Universal Vests (UVests/Pro Series/UKV), and is medically necessary for him/her as prescribed.

Medical History:

Patient Name:		
Patient Age:	Male | Female	In My Care Since:
Patient Diagnosis:		
His/Her Medical History is described as:		

The attached medical records document my patient's clinical condition and medical necessity for the use of the Universal Vests (UVests/Pro Series/UKV) to assist with ambulation, lifts and transfer maneuvers. Based on the above facts, I am confident that you will agree that the Universal Vests (UVests/Pro Series/UKV) is indicated and medically necessary for this patient.

Treatment Plan: Please consider coverage of the Universal Vests (UVests/Pro Series/UKV) on behalf of _____ and approve the use and subsequent payment for the Universal Vests (UVests/Pro Series/UKV) as planned. Please refer to the enclosed prescribing information for the Universal Vests (UVests/Pro Series/UKV). If you have any further questions, please do not hesitate to call our office at: _____.

Thank you for your prompt attention to this matter. Sincerely,

Physician Signature	Date Signed: