Medical Certificate of Need (UVests/Pro Series)

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

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

Patient Name:	
Group/Policy Number:	**Diagnosis Code:**

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

○ **Back/Lumbar/Sacral Pain** ○ **Lifts/Transfers** ○ **Gait Training** ○ **Coronal Region/Cervical Support**

Universal Vests (UVests/Pro Series) Needed:

○ **Universal Vests (UVests)** ○ **UVests Pro Series #_____**

This letter serves to document that _____ has a diagnosis of _____ and requires the utilization of the Universal Vests (UVests/Pro Series), 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) 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) is indicated and medically necessary for this patient.

The Universal Vest provides the necessary lumbar-sacral orthosis, sagittal control. The UVests has rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra which produces intracavitary pressure to reduce load on the intervertebral discs. The UVests will also assist the patient to maintain midline and symmetry in dynamic or static sitting or in standing. The UVests will also assist the patient with posture and maintain spine and thoracic stability as well. The UVests includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit this patient or a specific patient by an individual with expertise or thorough training of the Universal Vest.

Treatment Plan: Please consider coverage of the Universal Vests (UVests/Pro Series) on behalf of _____ and approve the use and subsequent payment for the Universal Vests (UVests/Pro Series) as planned. Please refer to the enclosed prescribing information for the Universal Vests (UVests/Pro Series). 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:**