Medical Necessity & Prescription

UE Ranger® - Upper Extremity Rehabilitation Device

Patient Name:			
Street Address:	City:	State:	Zip:
Patient DOB:		Phone:	

Medical Necessity

Diagnosis Necessitating UE Ranger:	ICD-10 Code
Affected Side (circle): Right Left Both	Date of Incident:
Upper Extremity Functional Limitations:	

Patient's need for the UE Ranger (mark all that apply):

- ☐ Increase range of motion
- ☐ Neuromuscular Re-education
- ☐ Support of effective HEP between therapy sessions
- ☐ Therapeutic strengthening
- ☐ An effective alternative as patient is unable to safely utilize Codman's Pendulum exercises
- ☐ Other ________________________________

Anticipated Outcome (mark all that apply):

- ☐ Pain resolution
- ☐ Compensatory free biomechanics
- ☐ Increased range of motion
- ☐ Restoration of strength and functional movement
- ☐ Efficient and effective use of therapy resources
- ☐ Optimization of patient recovery
- ☐ Other ________________________________

Prescription

☐ UE Ranger®		
☐ UE Ranger® Door Mount		
I certify that the above prescribed equipment is medically indicated and in my opinion is reasonable and necessary to support this patient's treatment.		
Physician's Signature:	Date:	
Physician:	Phone:	NPI:
Address:		

Clinical research studies available on the professional page at www.ueranger.com