Medical Certificate of Need

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

Re: Letter of Medical Certificate of Need for the UVests Pro Vests

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

I am writing on behalf of my patient, _____ to request authorization for the treatment and use of the UVests Pro Vests, to assist the patient with ambulation, lifts and transfer maneuvers.

UVests Pro Vest Needed:

- ◯ **UVests Pro 1PCL – (Padded) TLSO with Rigid Chest and Lateral Panels**
- ◯ **UVests Pro 1CL – TLSO with Rigid Chest and Lateral Panels**
- ◯ **UVests Pro 2PC – (Padded) TLSO with Rigid Chest Panels**
- ◯ **UVests Pro 2C – TLSO with Rigid Chest Panels**
- ◯ **UVests Pro 3PL – (Padded) TLSO with Rigid Lateral Panels**
- ◯ **UVests Pro 3L – TLSO with Rigid Lateral Panels**
- ◯ **UVests Pro 4PCL – (Padded) LSO with Rigid Chest and Lateral Panels**
- ◯ **UVests Pro 4CL – LSO with Rigid Chest and Lateral Panels**
- ◯ **UVests Pro 5PC – (Padded) LSO with Rigid Panels**
- ◯ **UVests Pro 5C – LSO with Rigid Panels**
- ◯ **UVests Pro 6PL – (Padded) LSO with Rigid Lateral Panels**
- ◯ **UVests Pro 6L – LSO with Rigid Lateral Panels**
- ◯ **UVests Pro 7P – (Padded) LSO**
- ◯ **UVests Pro 7 – LSO**

This letter serves to document that _____ has a diagnosis of _____ and requires the utilization of the UVests Pro Vests, 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 UVests Pro Vests to assist with ambulation, lifts and transfer maneuvers. Based on the above facts, I am confident that you will agree that the UVests Pro Vests is indicated and medically necessary for this patient.

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