RelieVRx

Customer Support: 1 (844) 728-4487
Fax Completed Forms: 1 (877) 552-1753
www.RelieVRx.com

1. Complete this form.
2. Confirm coverage criteria and medical necessity documentation requirements are met/filled out.
3. Fax this form with the patient's **medical chart face sheet**, recent **visit notes** and **medical necessity documentation** to: 1 (877) 552-1753.

Patient Information

Patient First Name _____ **Patient Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Date of Birth (MM/DD/YYYY) _____ **Gender:** ☐ Female ☐ Male ☐ Non-binary

Phone Number _____ **Email** _____

Emergency Contact _____ **Emergency Contact Phone:** _____

Prescriber Information

Prescriber First Name _____ **Prescriber Last Name** _____

NPI Number _____ **Prescriber Email** _____

Location Address _____

City _____ **State** _____ **Zip Code** _____

Phone Number _____ **Fax Number** _____

Prescription

Diagnosis Code: (Select All That Apply)

☐ **M54.50** (Low Back Pain, Unspecified)

☐ **M54.51** (Vertebrogenic Low Back Pain)

☐ **M54.59** (Other Low Back Pain)

☐ _____ Other

Notes: _____

Prescribing Information

Item To Dispense: RelieVRx
Dispense: One VR Device. Dispense As Written.

Length Of Need: 3 Months
Frequency Of Use: 1 Session Daily

Prescriber Authorization

I certify that the patient's record contains supporting documentation which substantiates the utilization and medical necessity of RelieVRx.
I understand the indications for use and associated warnings and precautions of the RelieVRx product I have prescribed herein.

Prescriber Signature _____ **Date** _____