FLOW THERAPY

Certificate of Medical Necessity

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FLOWTHERAPY.COM

Patient Information

Patient Name: ______________________ DOB: __________

Patient Phone: ______________________ Referring Provider: ______________________

(1) , (2) , and (3) In This Section Must be Completed to Ensure Coverage

01.

- ◯ Angina: Class III or IV (CCS) **_*Class III defined as symptomatic at 1-2 city blocks_**

OR

- ◯ AHA Angina Equivalency: III or IV (CCS)

_______ *Shortness of Breath with Exertion*
_______ *Limitations with Activities of Daily Living*
_______ *Need Nitroglycerin PRN*
_______ *Fatigue*

02.

- ◯ Not Easily Amenable for Surgical Intervention/High Risk

OR

- ◯ Patient is Unwilling to Undergo Invasive Procedure

03.

- ◯ Diagnosed with Coronary Artery Disease (CAD, ASCVD)

_______ *Obstructive Disease*
_______ *Non-Obstructive Disease (INOCA)*

- ◯ Long COVID

Evaluate & Treat with EECP Therapy + Lifestyle Management

Physician Signature: ______________________ Date: __________

In making this referral, referring physician certifies that prescribed procedure is of medical necessity.

Please Email or Fax the Available Supporting Documents:

- Patient Demographic / Insurance Sheet
- Recent Physician Notes / Last Office Visit
- Cardiac Catheterization Reports
- Recent Hospitalization Discharge
- Nuclear Report
- Echocardiogram Report