FLOW THERAPY

Certificate of Medical Necessity

P 972.490.9500 F 800.269.3147
or myfax.dls@flowtherapy.com

FLOWTHERAPY.COM

Patient Information

Patient Name: _____ DOB: _____

Patient Phone: _____ Medical Record Number *(if applicable)*: _____

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