NCOS
NORTHCOAST ORTHOPEDIC SALES

Northcoast Orthopedic Sales, LLC - VR CBT Referral Form

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____

DOB: ____/____/____ PHONE NUMBER: (____)____-_____ GENDER: M ☐ F ☐

PATIENT ADDRESS:

_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ PRIMARY INSURANCE ID #:
_____

SECONDARY INSURANCE NAME: _____ SECONDARY INSURANCE ID #:
_____

PRESCRIPTION INFORMATION

DIAGNOSIS CODE: _____

LENGTH OF NEED: 99

PRODUCT DETAILS	ORDER DETAILS
PRODUCT NAME: VIRTUAL REALITY COGNITIVE BEHAVIORAL THERAPY (CBT) DEVICE DISPENSE (E1905)	START DATE: ____/____/____

TREATMENT PLAN

REFERRING PHYSICIAN INFORMATION

FIRST NAME: _____ LAST NAME: _____ NPI: _____

PROVIDER SIGNATURE: _____ SIGNATURE DATE: ____/____/____

OFFICE NUMBER : _____ OFFICE FAX: _____

OFFICE ADDRESS:

_____

PLEASE SEND VIA FAX: (877) 496-2071 **OR EMAIL:** intake@northcoastorthopedics.com

Send together with the patient's face sheet and the doctor's notes.