Continuous Passive Motion (CPM) Medical Questionnaire

(Provider)

Participant: _____ **MPI ID:** _____ **DOS:** _____

Patient: _____ **Date:** _____

The Plan covers services considered reasonable and necessary in connection with the diagnosis and treatment of any non-industrial illness or injury. The information provided below will assist us in expediting your request.

1. Diagnosis: _____
2. Date of surgery: _____
3. What is the Specific Indication for CPM:

_____

_____

_____

4. Length of Time required: _____
5. Please submit Physical Therapy Records to include Range of Motion Progress.

Your cooperation is appreciated.

Please print legibly.

Physician's Name: _____ Date _____

Address: _____

Telephone: _____FAX _____

_____

Physician's Signature Date

Return completed form to the Medical Review Department:
MPIHP, P.O. Box 1999, Studio City, California 91614-0999