Joint Active Systems
Statement of Medical Necessity and/or Prescription

Prescription Start Date: _____

Patient Name: _____ DOB: _____
First Last MI

Address: _____
Street

_____
City State Zip Code

*******IMPORTANT: Please List Diagnosis, NOT Procedure Codes Below*******

Diagnosis (Primary): _____

Diagnosis (Secondary): _____

Date of Injury: _____

Reason For Prescribing A Joint Active Systems Device: ***The JAS system has been proven effective in the permanent elongation of soft tissue and restoration of range of motion. Required daily wear time (30 minutes, 3 times per day) is significantly less than other methods such as Dynamic Splint Therapy. The JAS system is patient controlled resulting in higher compliance. JAS devices provide full range therapy in one device. There are no substitutes for JAS.***

DISPENSE AS WRITTEN – DO NOT SUBSTITUTE

JAS Ankle_____ JAS Elbow_____ JAS Knee_____ JAS Shoulder_____

JAS Wrist_____ JAS Supination/Pronation _____ JAS Finger_____ JAS EZ Toe _____

Estimated Duration of Treatment: _____1-5 Months _____ 99 Months (=Lifetime)

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Physician Name (Printed): _____
First Last

Address: _____
Street

_____
City State Zip Code

Signature: _____ Date: ____/____/____