



Continuous Passive Motion (CPM) Medical Questionnaire (Provider)

Participant: _____ **SSN:** _____ **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 _____