

## CRANIAL HELMET QUESTIONNAIRE

PARTICIPANT: \_\_\_\_\_ SSN: \_\_\_\_\_

PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

**It is recommended that this Cranial Helmet questionnaire be submitted to the Plan to verify coverage of the equipment. Please have the attending physician complete the following information:**

Head measurements: \_\_\_\_\_

Age: \_\_\_\_\_

Description of type of asymmetry (either by measurement or by description of which area is flattened and some qualitative indication of severity):

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Has craniosynostosis been ruled out? \_\_\_\_\_ Yes \_\_\_\_\_ No

Describe any torticollis: \_\_\_\_\_

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**\*\*Please attach documentation regarding the effect of repositioning therapy performed.**

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

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Physician's name, address, and telephone number (please print)

Return the completed form and requested documentation to:

MPIHP - Medical Review Department  
P.O. Box 1999  
Studio City, CA 91614-0999