**FreeArm Muscle Letter of Medical Necessity**

A loose template for providers to alter then copy and paste into their own branded forms

**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Insurance company’s name)*

**From:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Physician’s name)*

**Subject: Request for coverage/reimbursement for FreeArm®**

FreeArm with clip: Item #- 001001X, HCPCS: B9998

FreeArm with clip billed separately: Item #- FAM001001X, HCPCS: E0776 + A9900

Based on my patient’s need of a portable way to administer tube feeds and/or infusions, I am requesting insurance coverage/reimbursement for, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Name)*, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*DOB as MM/DD/YYY)*, whom I have prescribed the use of the **FreeArm®.**

My patient’s feeding and/or infusion regimen: (Check all that apply)

Syringe Gravity Feeds

Pump Feeds

Infusions

\_\_\_\_\_\_\_\_\_\_\_\_\_ feeds/infusions per day, every \_\_\_\_\_\_\_\_\_\_\_\_\_\_hours

Additional info:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The benefits of the FreeArm Muscle in addition to an enteral pump backpack and IV pole may include:

• The FreeArm holds a feeding pump along with a syringe for feeding and venting using the FreeArm clip. Venting decreases abdominal distention/bloating, and nausea, and may decrease the risk of vomiting and aspiration.

• The FreeArm keeps pump bag lines free from kinks, therefore allowing the pump to continue infusing.

• The FreeArm is lightweight and portable and may be carried between rooms and up/down stairs.

• The FreeArm clamps to a wheelchair or stroller and may move with the patient.

• The FreeArm has the ability to deliver a more consistent feed by regulating gravity syringe feeds with the bendable arm. This may lead to better tolerance, better adherence to the nutrition prescription. and improved nutritional outcomes.

Your approval of this request would have a significant positive impact on my patient’s health and quality of life.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of prescribing MD, PA-C, ARNP with title Date*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Printed name of prescribing MD, PA-C, ARNP with title*

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*Name of Center/Hospital/Institution/Practice*