



Continuous Passive Motion (CPM) Device for Use on Lower Extremity

Completion of this form is required for the continued authorization of a Continuous Passive Motion (CPM) Device—Extension Beyond 21 Days.

Please fax the completed form to the applicable plan listed below:

- Tufts Health Plan Commercial Plans; Fax: 617.972.9409
- Tufts Health Direct – Health Connector; Fax: 888.415.9055
- Tufts Health Together – A MassHealth Plan; Fax: 888.415.9055
- Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
- Tufts Health Freedom Plan products; Fax: 617.972.9409

Member Name:	Member ID:	DOB:	Date of Request:
Diagnosis:	Joint Affected:	Date of Surgery:	Type of Surgery:
Original Dates of CPM Use:	Requested Authorized Extension Date From: To:		
ACTIVE RANGE OF MOTION (ROM) in degrees:			
Initial Joint ROM:			
Current Joint ROM:			
Weight bearing status:			
Time frame for non-weight bearing status, if applicable:			
PASSIVE RANGE OF MOTION in degrees:			
Initial Joint ROM:			
Current Joint ROM:			
Current Functional Level with Affected Joint (including stairs, ambulation, transfers):			
Treatment goal, including ROM and functional status to be achieved:			
Ordering Physician:	Requesting Provider (Name and Title):		
Provider Phone Number:	Provider Signature:		

[Provider Services](#)