



XRHealth VR CBT Order Form
Please Fax signed form to: 888-830-5780

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____
DOB: ____/____/____ PHONE NUMBER: (____)____-____ GENDER: M ☐ F ☐
PATIENT ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ PRIMARY INSURANCE ID #: _____

SECONDARY INSURANCE NAME: _____ SECONDARY INSURANCE ID #: _____

PRESCRIPTION INFORMATION

DIAGNOSIS CODE*: _____ *You may choose multiple diagnosis codes.

LENGTH OF NEED: 99

PRODUCT DETAILS

ORDER DETAILS

PRODUCT NAME:
VIRTUAL REALITY COGNITIVE BEHAVIORAL THERAPY (CBT)
DEVICE DISPENSE (E1905)

START DATE: ____/____/____

CLINICAL CONTENT* *Choose one and please make sure that the selected content corresponds with your diagnosis code.

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| ☐ VR CBT
Immersive cognitive behavioral therapy with guided mental health and chronic pain support. | ☐ VR CBT & COGNITIVE REHABILITATION THERAPY
Includes everything in VR CBT plus immersive neurocognitive training to support memory, attention, and cognitive function. |
| ☐ VR CBT & PHYSICAL THERAPY
Includes everything in VR CBT plus movement-based virtual rehabilitation exercises to support physical recovery and functional improvement. | ☐ ALL
Includes the full XRHealth therapeutic program with behavioral health, chronic pain, physical rehabilitation, and cognitive training. |

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

FIRST NAME: _____ LAST NAME: _____ NPI: _____
OFFICE NUMBER : _____ OFFICE FAX: _____
OFFICE ADDRESS: _____

CLINICIAN INFORMATION

FIRST NAME: _____ LAST NAME: _____ NPI: _____
SUPERVISING CLINICIAN SIGNATURE: _____ SIGNATURE DATE: ____/____/____
OFFICE EMAIL: _____ OFFICE NUMBER : _____ OFFICE FAX: _____
OFFICE ADDRESS: _____