



XRHealth VR CBT Order Form

Please Fax signed form to: 888-830-5780

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____

DOB: ____/____/____ PHONE: (____) ____-____ GENDER: ☐ M ☐ F

PATIENT ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ ID #: _____

SECONDARY INSURANCE NAME: _____ ID #: _____

PRESCRIPTION INFORMATION

★ DIAGNOSIS CODE (ICD-10) – REQUIRED ★

DX CODE(S):



You may enter multiple diagnosis codes.

Ensure the clinical content selected below corresponds with the DX.

LENGTH OF NEED: 99

PRODUCT NAME: VIRTUAL REALITY (VR) COGNITIVE BEHAVIORAL THERAPY (CBT)

DEVICE DISPENSE (E1905)

START DATE: ____/____/____

CLINICAL CONTENT - Choose one

(Ensure the treatment plan corresponds with the diagnosis code.)

☐ **VR CBT** - Immersive cognitive behavioral therapy with guided mental health & chronic pain.

☐ **VR CBT & PHYSICAL THERAPY** - Includes everything in VR CBT plus movement-based virtual rehabilitation exercises to support physical recovery and functional improvement.

☐ **VR CBT & COGNITIVE REHABILITATION THERAPY** - Includes everything in VR CBT plus immersive neurocognitive training to support memory, attention, and cognitive function.

☐ **ALL** - Includes the full XRHealth therapeutic program with behavioral health, chronic pain, physical rehabilitation, and cognitive training.

PRESCRIBING CLINICIAN

FIRST NAME: _____ LAST NAME: _____ NPI: _____

SIGNATURE: _____ SIGNATURE DATE: ____/____/____

OFFICE NUMBER: _____ OFFICE FAX: _____

OFFICE ADDRESS: _____