Active Ice Cold Therapy System: Reimbursement Request

Today's date:
Plan Name:
Plan Address:
Plan Address:

To whom it may concern:

Please refund to me $_________ for the purchase of a circulating cold water therapy system (HCPCS code E0236) that was prescribed by my physician. A copy of the prescription is enclosed.
A copy of my receipt is also enclosed.

Please send payment to:
Mr/Ms _________________________
____
____

My phone number is ___________________

My insurance policy, Medicare/Medicaid number(s) are:
____
____

Very Truly Yours,
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