exogen®
REWARDS PROGRAM

Attestation Form

Must be signed by prescribing healthcare professional (HCP)

Today's Date:			
Prescribing HCP Name:			
HCP Address:			
	City:	State:	Zip:
Patient Name:			
Fracture Diagnosis:			
Date of EXOGEN Prescription:			
EXOGEN Serial Number: (Back of Device)			
Additional Information:			

I confirm that I prescribed the EXOGEN Ultrasound Bone Healing System for this patient and that their fracture healed prior to 120 days of using the device by evaluation of the latest X-ray image.

Must be signed by prescribing healthcare professional (HCP)

Print:

Signature: Date:

Please print and sign this document.

Please complete, sign, and return this form to:
Bioventus LLC
Attn: Kimberly Miller
Director, Reimbursement Services
1900 Charles Bryan Road, Suite 275
Cordova, TN 38016

or fax to: 866-486-2195

bioventus®
Innovations For Active Healing