

# ICEMAN® CLEAR<sup>3</sup>

## THE CLEAR ADVANTAGE

### DONJOY® ICEMAN® CLEAR<sup>3</sup> (Premium Edition)

The IceMan CLEAR<sup>3</sup> cold therapy unit helps reduce pain and swelling. The IceMan helps provide extended cold therapy as directed by a medical professional. The IceMan CLEAR<sup>3</sup> utilizes DonJoy's patented recirculation technology, which helps maintain more consistent and accurate temperatures.

The information contained in this order form is not a substitute for the Operating Instructions that are to be provided with the cold therapy unit. By signing the order form on the reverse, you acknowledge that you must carefully read and follow the Instructions for Use (IFU) that are provided with the cold therapy unit before use. You also acknowledge that you must immediately contact your physician for medical treatment advice if you experience any physical discomfort when using the cold therapy unit. Extreme care must be taken when using any cryotherapy as it may cause cold injury if improperly used.

#### THIS IS A NON-COVERED / NON-REIMBURSABLE PRODUCT

#### STEPS FOR ORDERING

1. Obtain your physician's authorization signature on this order form.
2. Fill out your credit card and shipping information below.
3. Fax or email this form with physician's information, physician signature and credit card information to 1 (800) 936-6569 or [order.entry@djoglobal.com](mailto:order.entry@djoglobal.com).



#### 1) DONJOY® ICEMAN® CLEAR<sup>3</sup> COLD THERAPY PRESCRIPTION

#### PHYSICIAN AUTHORIZATION

I authorize the use of the DonJoy® IceMan® CLEAR<sup>3</sup> cold therapy unit for this patient.

Patient Name	Patient Date of Birth	
Physician Name (please print)	Physician Phone Number	NPI#
Physician Address	Physician Signature	Date

\*My signature above means that, in my judgment, the above prescribed product is medically indicated and necessary, and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.






# ICEMAN<sup>®</sup> CLEAR<sup>3</sup>

## 2) COLD THERAPY ORDER FORM

Email to [order.entry@djoglobal.com](mailto:order.entry@djoglobal.com) or FAX form to 1 (800) 936-6569

To receive the DonJoy<sup>®</sup> IceMan<sup>®</sup> CLEAR<sup>3</sup>, complete this form. Your credit card will be billed for the cold therapy unit plus shipping and applicable sales tax. This order must have a physician's authorization. For questions please call DJO<sup>®</sup> Customer Service at 1 (800) 336-6569 or email [customer.care@djoglobal.com](mailto:customer.care@djoglobal.com)

### Check Appropriate Box

Description		Qty.	Price: \$149.99
<input type="checkbox"/> DonJoy IceMan Clear <sup>3</sup> with Universal Wrap-On Pad, NS, RH (P/N: 11-1631)			
<input type="checkbox"/> DonJoy IceMan Clear <sup>3</sup> with Shoulder, S Wrap-On Pad, NS, EH (P/N: 11-1635)			
<input type="checkbox"/> DonJoy IceMan Clear <sup>3</sup> with McGuire Knee Wrap-On Pad, NS, RH (P/N: 11-1636)			
<input type="checkbox"/> DonJoy IceMan Clear <sup>3</sup> with Ankle Wrap-On Pad, NS, RH (P/N: 11-1638)			
<b>Shipping (SEE Shipping Chart)</b>			
<b>Total</b>			

### SHIPPING OPTIONS

Standard Ground Shipping - \$10  
2nd Business Day\* - \$15  
Overnight-Next Business Day\* - \$20

**\*Orders must be received  
by 12:00 P.M. PST / 2:00 P.M. EST**

**For additional DonJoy Cold Therapy  
products and other items, please visit  
[www.DJOGlobal.com](http://www.DJOGlobal.com)**

**WARNING THIS DEVICE CAN BE COLD  
ENOUGH TO CAUSE SERIOUS INJURY.  
DO NOT use this device without  
a prescription from a physician.**

**NOTE: Applicable sales tax will be applied to your order.**

**S** = Sterile    **NS** = Non-Sterile    **RH** = Regular Hose (6.5")    **EH** = Extended Hose (15")

## 3) DJO Account# 600010 THIS IS A NON-COVERED / NON-REIMBURSABLE PRODUCT.

### PAYMENT: CREDIT CARD ONLY

<input type="checkbox"/> Master Card	<input type="checkbox"/> Visa	<input type="checkbox"/> American Express	<input type="checkbox"/> Discover
Credit Card Number		CVC 3 digit security code / 4 digit security code on AmEx	
Expiration Date		Signature*	

### BILLING ADDRESS

### SHIPPING ADDRESS

Name (As it appears on your credit card)			Name		
Billing Address (As it appears on your credit card)			Billing Address		
City	State	Zip	City	State	Zip

\*My signature indicates that the information I have provided above is true and accurate. My signature also indicates that the information included in the physician authorization section was completed by my healthcare provider and that this product is being prescribed for me as part of a treatment protocol established by my provider. I further understand that neither DJO<sup>®</sup> nor any distributor will bill my insurance company for this product and that I am responsible for payment in full. If I am a Medicare patient, I understand that Medicare does not reimburse for this product, that neither DJO nor any distributor will bill Medicare, and that I am responsible for payment in full.



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