**PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FOR ELBOW ORTHOSIS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Please Send RX Form & Pertinent Chart Notes** | | | **Fax No: (305) 390 3669** |
|  | **PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS** | | | |
|  |  | |  |  |
| Date: | ${order\_date} | |  |  |
| First: | ${fname} Last: ${lname} | | Physician Name: ${phy\_name} | |
| DOB: | ${dob} | | NPI: | ${phy\_npi} |
| Address: | ${address} | | Address: | ${phy\_address} |
| City: | ${city} | | City: | ${phy\_city} |
| State: | ${state} | | State: | ${phy\_state} |
| Postal Code: | ${postal\_code} | | Postal code: | ${phy\_postal\_code} |
| Patient Phone Number: ${phone\_num} | | | Phone Number: ${phy\_phone\_num} | |
| Primary Ins: ${primary\_ins} | | Policy #: ${policy\_num} | Fax Number: ${phy\_fax} | |
| Private Ins:${private\_ins} | | Policy #: - |  |  |
| Height: ${height} | | Weight: ${weight} |  |  |
|  | |  |  |  |

*This patient is being treated under a comprehensive plan of care for Elbow pain.*

*I, the undersigned; certify that the prescribed orthosis is medically necessary for the patient’s overall well-being. This patient suffered injury has undergone surgery, or has arthritis. In my opinion, the following elbow orthosis products are both reasonable and necessary in reference to treatment of the patient’s condition and/or rehabilitation. My patient has been in my care regarding the diagnosis below. This is the treatment I see fit for this patient at this time. I certify that this information is true & correct***.**

**DIAGNOSIS:** Provider can simply cut off the diagnosis which they don’t find appropriate

Cubital Tunnel Syndrome (G56.2)

Rheumatoid bursitis, right elbow (M06.221)

Rheumatoid Bursitis, left elbow (M06.222)

Pain in right elbow (M25.521)

Pain in left elbow (M25.522)

Unspecified sprain of right elbow (S53.401)

Unspecified sprain of left elbow (S53.402)

Disorder of ligament, right elbow (M24.221)

Disorder of ligament, left elbow (M24.222)

Other /Explain (Include code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AFFECTED AREA:**

ELBOW**:**

Left

****

Right

****

***Our evaluation of the above patient has determined that providing the following Elbow orthosis product will benefit this patient:***

**DISPENSE:**

L3761: ELBOW ORTHOSIS (EO), WITH ADJUSTABLE POSITION LOCKING JOINT(S), PREFABRICATED, OFF-THE-SHELF

Length of need is 99 months unless otherwise specified: \_\_\_\_\_ 6 - 99 (99= LIFETIME)

${phy\_signature:100:80} ${phy\_signed\_date}

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Name:** ${phy\_name}. **NPI:** ${phy\_npi}