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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Please Send RX Form & Pertinent Chart Notes** | | | **Fax No:3053903669** |
|  |  | **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 wrist pain.*

*I, the undersigned; certify that the prescribed orthosis is medically necessary for the patient’s overall well-being. This patient has suffered injury and/or undergone surgery. In my opinion, the following orthosis product is 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

Primary Osteoarthritis, Both wrists (M19.031), (M19.032)

Primary Osteoarthritis, Right Hand (M19.41)

Primary Osteoarthritis, Left Hand (M19.42)

Carpal Tunnel Syndrome, Right Upper Limb (G56.01)

Pain In Right Wrist (M25.531)

Carpal Tunnel Syndrome, Left Upper Limb (G56.02)

Pain In Left Wrist (M25.532)

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

**AFFECTED AREA**:WRIST: Left **** Right ****

***Our evaluation of the above patient has determined that providing the following Wrist Orthosis Product will benefit this patient:***

**DISPENSE:**

L3916: WRIST HAND ORTHOSIS (WHO), INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF

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

${phy\_signature} ${phy\_signed\_date}

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

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