**PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FOR SHOULDER 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 shoulder pain.*

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

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

M75.32 Calcific tendinitis of left shoulder

M75.42 Impingement syndrome of left shoulder

G56.12 Other lesions of median nerve, left upper limb

G56.32 Lesion of radial nerve, left upper limb

M25.512 Pain in Left Shoulder

Other /Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AFFECTED AREA:**

SHOULDER: Left Shoulder ****

**DISPENSE:**

**L3960**: SHOULDER ELBOW WRIST HAND ORTHOSIS (SEWHO), ABDUCTION POSITIONING, AIRPLANE DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

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}