**PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FOR WRIST 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 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**

Pain In Left Wrist (M25.5)

Primary Osteoarthritis, Left Wrist (M19.032)

Primary Osteoarthritis, Left Hand (M19.04)

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

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

**AFFECTED AREA:**

WRIST: Left ****

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

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

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