

Service Date:

Patient Information	Doctor Information
Name:	Name:
DOB :	NPI:
Phone:	Phone:

Pages Including Cover: 2

---Patient Information Sheet---	
PLEASE COMPLETE AND FAX BACK ASAP TO:	
Attention: _____	
Date of Last Visit: _____	
Reason for Visit: _____	

Allergies: _____	

Current Medications: _____	

Affected Area: _____	

Please remember to circle quantity and refill amount for the attached RX your patient has requested from our company.	
PAT ID #:	

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Patient

Physician's Written Order

Name:

DOB:

Please FAX

Address:

City/State/Zip:

this completed order
to

Phone Number:

Modality & DX Code

☐ Back Brace (LSO) L0650:

- ☐ Low Back Pain M54.5*
- ☐ Spinal Stenosis, Lumbar Region M48.061*
- ☐ General Muscle Weakness M62.81*
- ☐ Intervertebral Disc Displacement M51.26*
- ☐ Lumbar Spondylosis M47.896*
- ☐ Lumbar Intervertebral Disc Degeneration M51.36*

☐ Knee Brace L1851:
w/Suspension Sleeve L2397

- ☐ Chondromalacia of Patella M22.41 and/or M22.42*
- ☐ Chronic Instability of Knee M23.51 and/or M23.52*
- ☐ Rheumatoid Arthritis w/ Rheumatoid Factor M05.861 and/or M05.862*
- ☐ Osteoarthritis - Knee (Unspecified) M17.9*
- ☐ Multiple Sclerosis G35*

☐ Ankle Brace L1906:

- ☐ Contracture, (Ankle/Foot) M24.571 and/or M24.572*
- ☐ Ligament Sprain S93.491A and/or S93.492A
- ☐ Ligament Sprain S93.491D and/or S93.492D
- ☐ Sprain S93.601A and/or S93.602A
- ☐ Sprain S93.601D and/or S93.602D

☐ Wrist Brace L3916:

- ☐ Carpal Tunnel Syndrome G56.01 and/or G56.02
- ☐ Pain in Wrist M25.531 and/or M25.532*
- ☐ Unspecified Sprain of Wrist S63.501A and/or S63.502A
- ☐ Sprain of Carpal Joint of Wrist S63.511A and/or S63.512A
- ☐ Unspecified Sprain of Wrist S63.501D and/or S63.502D

☐ Elbow Brace:

- ☐ Effusion M25.421 and/or M25.422*
- ☐ Recurrent Dislocation M24.421 and/or M24.422*

☐ Shoulder Brace L3670:

- ☐ Adhesive Capsulitis M75.01 and/or M75.02
- ☐ Impingement Syndrome M75.41 and/or M75.42*
- ☐ Primary Osteoarthritis M19.011 and/or M19.012*
- ☐ Pain in Shoulder M25.511 and/or M25.512*

☐ Cervical Brace:

- ☐ Cervicalgia M54.2*
- ☐ Radiculopathy M54.02*
- ☐ Spinal Stenosis, Cervical Region M48.02
- ☐ Osteoarthritis M19.90*

☐ Other: _____☐ Other: _____

Medical Necessity & Length of Need

- ☐ Support weak spinal muscles and/or deformed spine
- ☐ Facilitate healing following injury to the spine or related soft tissue
- ☐ Reduce pain by restricting mobility of the trunk
- ☐ Facilitate healing following a surgical procedure on the spine or related soft tissue
- ☐ Facilitate healing post injury or surgery
- ☐ Weakness or deformity of the foot and ankle
- ☐ Reduce pain by restricting joint movement

Length of need (Length of need is LIFETIME [99 months] unless otherwise noted)

Physician Name, Credentials, NPI#, Signature & Date

No substitutions allowed. – In my opinion, in accordance with accepted medical practice standards, the above named patient requires the Home Medical Equipment Provider's product(s) (no substitutions allowed) as dispensed by Home Medical Equipment Provider for the problems identified above. By my signature below, I certify that the information contained herein is a true and correct verification of my verbal or written order and that my medical records support the medical need for the items prescribed. I further certify, if I am a non-physician healthcare provider, that I have all necessary licensure and the authorization under applicable state and federal law to treat this patient for his or her condition and to prescribe the above equipment and/or supplies. I hereby attest that the medical record entry for the date listed accurately reflects the signatures/notations that I made in my capacity listed above when I diagnosed/treated the Medicare beneficiary listed above. I do hereby further attest that this information is true, accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to administrative, civil or criminal liability.

ORDERING PHYSICIAN MUST REVIEW CONTENT AND SIGN & DATE DOCUMENT

Physician's Name (printed)

NPI #

Doctor Fax#

X

Physician's Signature (No Stamps)

Date (Signature date and start date are
same unless otherwise specified)

*The diagnosis codes provided should serve as a guide and should not be the only considered options for prescribing the product(s) listed. As the prescribing physician, you may circle a specific diagnosis code indicating your limited selection, you may check mark any selections and you may write in your own diagnosis on the "Other" line provided.

Detailed Descriptions: **L0650:** Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Anterior And Posterior Frame/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Lateral Strength Provided By Rigid Lateral Frame/Panel(S), Produces Intracavitary Pressure To Reduce Load On Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf **L0648:** Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Produces Intracavitary Pressure To Reduce Load On The Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf **L0642:** Lumbar Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From L-1 To Below L-5 Vertebra, Produces Intracavitary Pressure To Reduce Load On The Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf **L2397:** Addition To Lower Extremity Orthosis, Suspension Sleeve **L1833:** Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf **L1851:** Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf **L1820:** Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment. **L1906:** Ankle foot orthosis, multiligamentous ankle support, prefabricated, off-the-shelf. **L3760:** Elbow orthosis, with adjustable position locking joint(s), prefabricated, includes fitting and adjustments, any type. **L3960:** Shoulder elbow wrist hand orthosis, abduction positioning, airplane design, prefabricated, includes fitting and adjustment. **L3916:** Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf. **L0180:** Cervical, multiple post collar, occipital/mandibular supports, adjustable. **L3170:** foot, plastic, silicone or equal, heel stabilizer, prefabricated, off-the-shelf, each **L2810:** addition to lower extremity orthosis, knee control, condylar pad **L0984:** protective body sock, prefabricated, off-the-shelf, each