

ADDICKS MEDICAL SUPPLY

RX / MEDICAL NECESSITY FORM

PATIENT INFORMATION			SHIPPING METHOD: <input checked="" type="checkbox"/> SHIP TO PATIENT'S HOME ADDRESS <input type="checkbox"/> SHIP TO PATIENT'S PHYSICIAN CLINIC
SNYDER	JOANNE		
LAST NAME	FIRST NAME	MI	
FEMALE	10/02/1944	7188981375	
GENDER	DATE OF BIRTH	PHONE NUMBER	
5033 60TH ST FL 1	WOODSIDE	NY 11377	
ADDRESS	CITY	STATE & ZIPCODE	

INSURANCE INFORMATION	
MEDICARE	
PRIMARY INSURANCE	SECONDARY INSURANCE
5DE7DH2VP33	
MEMBER ID	MEMBER ID

PHYSICIAN INFORMATION	
DR. PARVIZ BENHURI, MD	1396861761
PHYSICIAN NAME	NPI #
	2125701111
50 E 72ND ST NEW YORK, NY 10021	PHONE NUMBER
PRACTICE LOCATION	2127444898
	FAX NUMBER

PRESCRIPTION SELECTION	
<input type="checkbox"/> L3670 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L3960 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L3660 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L0650 – Lumbar Brace (Waist:) <input type="checkbox"/> L0642 – Lumbar Brace (Waist:) <input checked="" type="checkbox"/> L0457 – Lumbar Brace (Waist: 39) <input type="checkbox"/> L0648 – Lumbar Brace (Waist:) <input type="checkbox"/> E0100 – Electric Heat Pad <input type="checkbox"/> L1690 – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist:) <input type="checkbox"/> L1686 – Hip Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Waist:) <input type="checkbox"/> L2624 – Hip Joint Adjustable Flexion, Extension (Side: <input type="checkbox"/> L <input type="checkbox"/> R) <input type="checkbox"/> L3760 – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R)	<input type="checkbox"/> L3761 – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input checked="" type="checkbox"/> L3916 – Wrist Hand Finger (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Size: LARGE) <input type="checkbox"/> L3915 - Wrist Hand Finger (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L1852 – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L1851 – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L1833 – Knee Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L2397 – Knee Sleeve (Size:) (Qty:) <input type="checkbox"/> E0100 – Cane <input type="checkbox"/> L2425 – Dial Lock Hinge ROM <input type="checkbox"/> L2820 – Lower Extremity Ortho <input type="checkbox"/> L1906 – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size:) <input type="checkbox"/> L1971 – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size:) <input type="checkbox"/> L0174 – Cervical Brace <input type="checkbox"/> L3170 – Heel Stabilizer (Side: <input type="checkbox"/> L <input type="checkbox"/> R)

MEDICAL INFORMATION	
ICD 10 (Diagnosis Code(s)):	
<input checked="" type="checkbox"/> M54.50- Low back pain, unspecified <input type="checkbox"/> M17.12- Unilateral primary osteoarthritis left knee <input type="checkbox"/> M17.11-Unilateral primary osteoarthritis right knee <input type="checkbox"/> M25.512-Pain in the left shoulder <input type="checkbox"/> M25.511-Pain in the right shoulder <input type="checkbox"/> M25.552- Pain in Left Hip <input type="checkbox"/> M25.551- Pain in Right Hip	<input checked="" type="checkbox"/> M25.532- Pain in left wrist <input checked="" type="checkbox"/> M25.531 - Pain in right wrist <input type="checkbox"/> M19.072- Osteoarthritis Left Ankle <input type="checkbox"/> M19.071- Osteoarthritis Right Ankle <input type="checkbox"/> M25.522 Pain in left elbow <input type="checkbox"/> M25.521 Pain in right elbow <input type="checkbox"/> M54.2-Cervicalgia Pain neck
Length of Need: <input checked="" type="checkbox"/> 12+ months (long term) <input type="checkbox"/> ____ # of months (1-11)	


MEDICAL HISTORY

Previous treatments: TAKING MEDICATION

Doctor's Notes: The patient reports chronic **Back, Left Wrist, Right Wrist** pain for **MORE THAN A YEAR**. Patient states pain is **DULL** with a pain scale of **6** and pain worsens with movements. Pain is caused by **WEAR AND TEAR** and is experienced **CONSTANTLY**. Previous treatments with heat, ice and rest have been unsuccessful to control pain level.

PHYSICIAN SIGNATURE

Physician Verification: By my signature, I am prescribing the items listed above and certifying that the above-prescribed item(s) is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

PHYSICIAN SIGNATURE:  PHYSICIAN NAME: DR. PARVIZ BENHURI, MD DATE: 09-12-2024

ADDICKS MEDICAL SUPPLY

Patient Name: **JOANNE SNYDER**
Patient Address: **5033 60TH ST FL 1 WOODSIDE NY 11377**
Patient Phone: **7188981375**

Physician Name: **DR. PARVIZ BENHURI, MD**
Address: **50 E 72ND ST NEW YORK, NY 10021**
Telephone: **2125701111**
Fax: **2127444898**

Patient: **JOANNE SNYDER**
Date of Birth: **10/02/1944**
Visit Date: **A MONTH AGO**
Reason for visit: **Check-up**

Clinical Summary

Patient Demographics

Patient Name:	JOANNE SNYDER	Date of Birth:	10/02/1944
Age:	79	Phone Number:	7188981375
Address:	5033 60TH ST FL 1	City:	WOODSIDE
State:	NY	Zip Code:	11377
Gender:	FEMALE	Height:	5'5
Weight:	135	Waist Size	39

Patient Insurance

Provider:	MEDICARE	Member ID:	5DE7DH2VP33
-----------	----------	------------	-------------

Medications

Current Medication	TYLENOL/AS NEEDED, ADVIL/AS NEEDED
Medical History	NONE

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 6
The patient's pain started on or around MORE THAN A YEAR
The surgery addressed the following: NA
The pain is experienced CONSTANTLY
The patient has attempted the following previous treatments/therapies: TAKING MEDICATION
The patient described their pain as the following: DULL
The activities that make the patient's pain worse is as follows: STANDING, WALKING
The pain is located in the patient's Back, Left Wrist, Right Wrist
The patient's pain is caused by WEAR AND TEAR
The last time the patient has seen the doctor was on A MONTH AGO

Chief Complaint

The patient's main complaint is that they experience chronic pain located in the following location(s): Back, Left Wrist, Right Wrist
--

Subjective Notes

The patient reports chronic Back, Left Wrist, Right Wrist pain for MORE THAN A YEAR . Patient states pain is DULL with a pain scale of 6 and pain worsens with movement. The pain is caused by WEAR AND TEAR and is experienced CONSTANTLY . Previous treatments with heat, ice, and rest have been unsuccessful to control pain level.

Objective of Assessment (Review of Symptoms)

Patient has chronic pain for MORE THAN A YEAR located in their Back, Left Wrist, Right Wrist related to M54.50- Low back pain, unspecified, M25.532- Pain in left wrist, M25.531- Pain in right wrist . Patient has been to a physical therapist and hasn't had previous surgery to treat this pain. Patient's chronic pain is described DULL and occurs CONSTANTLY . The patient rated their pain on a scale of 1-10 (10 being the worst) on a level 6 . The following activities make the patient's pain worse: STANDING, WALKING . Patient needs a Back, Left Wrist, Right Wrist Brace to provide support and reduce pain level.
--

ADDICKS MEDICAL SUPPLY

Plan & Treatment Goals

Based on my evaluation of the patient's condition, I am ordering the following device(s) **L0457 (TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF), L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF)**, including fitting and adjustment, if needed. The patient has been instructed to wear the device daily, as needed. The benefits of this device, which is an alternative, non-invasive method to potentially relieve pain, has been explained to the patient who is interested in this treatment. Based on my assessment, I have determined it is medically necessary and appropriate to prescribe treatment today. For the patient's complaint, I am prescribing this device. The patient will benefit by helping her address any of the following: give support to weak muscles, improve patient's pain, improve patient's function, increase performance in activities of daily living, improve ambulation, reduce medications, slow degeneration, provide stability, provide support. Reduce pain by restricting the mobility of the trunk; reduce the risk of medical problems escalating the patient's present condition, facilitate healing following an injury or surgical procedure to the spine or related soft tissues; To support weak spinal muscles and/or a deformed spine. If the patient's pain persists or worsens and/or there is an acute trauma or injury related to this pain, the patient agrees and understands to go to the Emergency Room or follow-up with their Primary Care Physician for further testing and imaging that may be immediately necessary.

ICD 10 (Diagnostic Codes)

M54.50- Low back pain, unspecified, M25.532- Pain in left wrist, M25.531- Pain in right wrist

Agreements

We understand that you are choosing to use our professional medical services to receive a prescription for your new brace.

Physician Information

Provider Name: **DR. PARVIZ BENHURI, MD**

Address: **50 E 72ND ST NEW YORK, NY 10021**

Physician's Signature:



09-12-2024

Date:

Patient Name: **JOANNE SNYDER**

Patient Address: **5033 60TH ST FL 1 WOODSIDE NY 11377**

Patient Phone: **7188981375**

ADDICKS MEDICAL SUPPLY

LETTER OF MEDICAL NECESSITY

Re: **JOANNE SNYDER**
Orthotic Device Need Assessment
Exam Date: **09/11/2024**
Height: **5'5**
Weight: **135**
DOB: **10/02/1944**

Ms SNYDER is inquiring about utilizing orthotic bracing for his/her current conditions. His/her chief complaint at the time of this assessment is:
Back, Left Wrist, Right Wrist.

Ms SNYDER reports chronic **Back, Left Wrist, Right Wrist** pain for **MORE THAN A YEAR**. Patient states pain is **DULL** with a pain scale of **6** and pain worsens with **STANDING, WALKING**. Pain is experienced **CONSTANTLY**. Previous treatments with heat, ice, medication and rest have been unsuccessful to control pain levels.

Diagnosis includes: **M54.50- Low back pain, unspecified, M25.532- Pain in left wrist, M25.531- Pain in right wrist**. Based on my conversation with **Ms SNYDER** and evaluation of his/her condition, I am ordering the following: **L0457 (TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF), L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF).**

Patient is ambulatory and has weakness of the **Back, Left Wrist, Right Wrist** requiring stabilization for improvement of functionality. I am prescribing this **Back, Left Wrist, Right Wrist** orthosis for the following indication(s): to aid when the patient is **STANDING, WALKING**, to aid in stabilization of the **Back, Left Wrist, Right Wrist**. My treatment goal(s) for the use of the prescribed **Back, Left Wrist, Right Wrist** orthosis are: improvement in patient's function, improvement in patient's pain. The patient has been instructed to use the brace(s) daily, as needed.

Custom fitting of the orthosis is not required and the patient or an assisting caregiver can apply the prescribed orthotic device with minimal self-adjustment. **Ms SNYDER** has been provided a phone number to call if there are any additional comments or questions regarding this examination, and I have recommended that **Ms SNYDER** continue medical follow-up as part of an ongoing plan of care.

Re: **JOANNE SNYDER..... DOB: October 02, 1944**

I, **DR. PARVIZ BENHURI, MD**, verify and confirm this order for the above-named patient, and certify that I have personally performed the assessment of the patient for the prescribed treatment and device and verify that it is reasonably and medically necessary, according to accepted standards of medical practice within the community, for this patient's medical condition.


DR. PARVIZ BENHURI, MD
Signature

Date Signed: 09-11-2024