

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
DARNELL	WARREN		
LAST NAME	FIRST NAME	MI	
MALE	06/05/52	3046851501	
GENDER	DATE OF BIRTH	PHONE NUMBER	
4220 MASON DIXON HWY	MAIDSVILLE	WV 26541	
ADDRESS	CITY	STATE & ZIPCODE	

INSURANCE INFORMATION	
MEDICARE	
PRIMARY INSURANCE	SECONDARY INSURANCE
2UC5MJ9XF64	
MEMBER ID	MEMBER ID

PHYSICIAN INFORMATION	
ANTHONY DAVID MARCUCCI M.D.	1437174851
PHYSICIAN NAME	NPI #
	304-241-7150
	PHONE NUMBER
1300 FORT PIERPONT DR STE 101 MORGANTOWN, WV 26508	304-554-2106
PRACTICE LOCATION	FAX NUMBER

PRESCRIPTION SELECTION	
<input type="checkbox"/> L3670 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L3670 – 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 type="checkbox"/> L0457 – Lumbar Brace (Waist:) <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: MEDIUM) <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"/> L1833 / L1851 – 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 checked="" type="checkbox"/> L1906 – Ankle Brace (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Shoe Size: 11) <input type="checkbox"/> L1971 – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size:) <input type="checkbox"/> L0174 – Cervical Brace <input checked="" type="checkbox"/> L3170 – Heel Stabilizer (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R)

MEDICAL INFORMATION	
ICD 10 (Diagnosis Code(s)):	
<input 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 checked="" type="checkbox"/> M19.072- Osteoarthritis Left Ankle <input checked="" 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 in Neck
Length of Need: <input checked="" type="checkbox"/> 12+ months (long term) <input type="checkbox"/> ____ # of months (1-11)	

ADDICKS MEDICAL SUPPLY

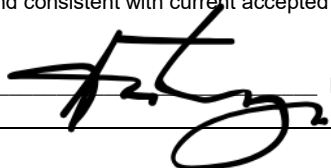
MEDICAL HISTORY**Previous treatments: TAKING MEDICATION**

Doctor's Notes: The patient reports chronic **LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST** pain for **A YEAR**. Patient states pain is **ACHY** 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: _____

ANTHONY DAVID MARCUCCI M.D.

DATE: _____

08-26-2024

ADDICKS MEDICAL SUPPLY

Patient Name: **WARREN DARNELL**
Patient Address: **4220 MASON DIXON HWY MAIDSVILLE WV 26541**
Patient Phone: **3046851501**

Physician Name: **ANTHONY DAVID MARCUCCI M.D.**
Address: **1300 FORT PIERPONT DR STE 101 MORGANTOWN, WV 26508**
Telephone: **304-241-7150**
Fax: **304-554-2106**

Patient: **WARREN DARNELL**
Date of Birth: **06/05/52**
Visit Date: **2 MONTHS AGO**
Reason for visit: **REGULAR CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	WARREN DARNELL	Date of Birth:	06/05/52
Age:	72	Phone Number:	3046851501
Address:	4220 MASON DIXON HWY	City:	MAIDSVILLE
State:	WV	Zip Code:	26541
Gender:	MALE	Height:	5'11
Weight:	200	Waist Size	38

Patient Insurance

Provider:	MEDICARE	Member ID:	2UC5MJ9XF64
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Medications

Current Medication	TYLENOL
Medical History	DIABETES HIGH BLOOD PRESSURE

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 A YEAR AGO
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: ACHY
The activities that make the patient's pain worse is as follows: WALKING
The pain is located in the patient's LEFT ANKLE, RIGHT ANKLE, 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 2 MONTHS AGO

Chief Complaint

The patient's main complaint is that they experience chronic pain located in the following location(s): LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST
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Subjective Notes

The patient reports chronic LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST pain for A YEAR. Patient states pain is ACHY 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.
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Objective of Assessment (Review of Symptoms)

Patient has chronic pain for A YEAR located in their LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST related to M19.071- Osteoarthritis Right Ankle, M19.072- Osteoarthritis Left Ankle, 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 ACHY 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: WALKING. Patient needs a LEFT ANKLE, RIGHT ANKLE, 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) **L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF), L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF INCLUDES L3170 HEEL STABILIZER** 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)

M19.071- Osteoarthritis Right Ankle, M19.072- Osteoarthritis Left Ankle, 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: **ANTHONY DAVID MARCUCCI M.D.**

Address: **1300 FORT PIERPONT DR STE 101 MORGANTOWN, WV 26508**

Physician's Signature:



Date:

08-26-2024

Patient Name: **WARREN DARNELL**

Patient Address: **4220 MASON DIXON HWY MAIDSVILLE WV 26541**

Patient Phone: **3046851501**

ADDICKS MEDICAL SUPPLY

LETTER OF MEDICAL NECESSITY

Re: **WARREN DARNELL**
Orthotic Device Need Assessment
Exam Date: **08/23/2024**
Height: **5'11**
Weight: **200**
DOB: **06/05/52**

Mr DARNELL is inquiring about utilizing orthotic bracing for his/her current conditions. His/her chief complaint at the time of this assessment is: **LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST**.

Mr DARNELL reports chronic **LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST** pain for **A YEAR**. Patient states pain is **ACHY** with a pain scale of 6 and pain worsens with **WALKING**. Pain is experienced **CONSTANTLY**. Previous treatments with heat, ice, medication and rest have been unsuccessful to control pain levels.

Diagnosis includes: **M19.071- Osteoarthritis Right Ankle, M19.072- Osteoarthritis Left Ankle, M25.532- Pain in left wrist, M25.531- Pain in right wrist**. Based on my conversation with **Mr DARNELL** and evaluation of his/her condition, I am ordering the following: **L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF), L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF INCLUDES L3170 HEEL STABILIZER**.

Patient is ambulatory and has weakness of the **LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST** requiring stabilization for improvement of functionality. I am prescribing this **WRIST, ANKLE** orthosis for the following indication(s): to aid when the patient is **WALKING**, to aid in stabilization of the **WRIST, ANKLE**. My treatment goal(s) for the use of the prescribed **WRIST, ANKLE** 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. **Mr DARNELL** has been provided a phone number to call if there are any additional comments or questions regarding this examination, and I have recommended that **Mr DARNELL** continue medical follow-up as part of an ongoing plan of care.

Re: **WARREN DARNELL**..... DOB: **June 05, 1952**

I, **ANTHONY DAVID MARCUCCI M.D.**, 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.


ANTHONY DAVID MARCUCCI M.D.
Signature

Date Signed

08-26-2024