

DV MEDICAL SUPPLY

RX / MEDICAL NECESSITY FORM

PATIENT INFORMATION

GARRISON

CAROL

LAST NAME

FIRST NAME

MI

FEMALE

12/03/1956

2019939702

GENDER

DATE OF BIRTH

PHONE NUMBER

412 UNION ST APT 1

JERSEY CITY

NJ 07304

ADDRESS

CITY

STATE & ZIPCODE

SHIPPING METHOD:

- ☒ SHIP TO PATIENT'S HOME ADDRESS
- ☐ SHIP TO PATIENT'S PHYSICIAN CLINIC

INSURANCE INFORMATION

MEDICARE

PRIMARY INSURANCE

7GP3UX7CX60

MEMBER ID

SECONDARY INSURANCE

MEMBER ID

PHYSICIAN INFORMATION

JEAN ROBERT DARBOUZE, MD

1639201510

PHYSICIAN NAME

NPI #

2014320809

230 BERGEN AVE JERSEY CITY NJ 07305

PHONE NUMBER

2014320074

PRACTICE LOCATION

FAX NUMBER

PRESCRIPTION SELECTION

- ☐ L3670 – Shoulder Brace (Side: ☐ L ☐ R) (Size:)
- ☐ L3960 – Shoulder Brace (Side: ☐ L ☐ R) (Size:)
- ☐ L3660 – Shoulder Brace (Side: ☐ L ☐ R) (Size:)
- ☐ L0650 – Lumbar Brace (Waist:)
- ☐ L0642 – Lumbar Brace (Waist:)
- ☐ L0457 – Lumbar Brace (Waist:)
- ☐ L0648 – Lumbar Brace (Waist:)
- ☐ E0100 – Electric Heat Pad
- ☐ L1690 – Hip Brace (Side: ☐ L ☐ R) (Waist:)
- ☐ L1686 – Hip Brace (Side: ☐ L ☐ R) (Waist:)
- ☐ L2624 – Hip Joint Adjustable Flexion, Extension (Side: ☐ L ☐ R)
- ☐ L3760 – Elbow Brace (Side: ☐ L ☐ R)

- ☒ L3761 – Elbow Brace (Side: ☒ L ☒ R) (Size: XL)
- ☒ L3916 – Wrist Hand Finger (Side: ☒ L ☒ R) (Size: XL)
- ☐ L3915 – Wrist Hand Finger (Side: ☐ L ☐ R) (Size:)
- ☐ L1852 – Knee Brace (Side: ☐ L ☐ R) (Size:)
- ☐ L1851 – Knee Brace (Side: ☐ L ☐ R) (Size:)
- ☐ L1833 – Knee Brace (Side: ☐ L ☐ R) (Size:)
- ☐ L2397 – Knee Sleeve (Size:) (Qty:)
- ☐ E0100 – Cane
- ☐ L2425 – Dial Lock Hinge ROM
- ☐ L2820 – Lower Extremity Ortho
- ☐ L1906 – Ankle Brace (Side: ☐ L ☐ R) (Shoe Size:)
- ☐ L1971 – Ankle Brace (Side: ☐ L ☐ R) (Shoe Size:)
- ☐ L0174 – Cervical Brace
- ☐ L3170 – Heel Stabilizer (Side: ☐ L ☐ R)

MEDICAL INFORMATION

ICD 10 (Diagnosis Code(s)):

- ☐ M54.50- Low back pain, unspecified
- ☐ M17.12- Unilateral primary osteoarthritis left knee
- ☐ M17.11- Unilateral primary osteoarthritis right knee
- ☐ M25.512- Pain in the left shoulder
- ☐ M25.511- Pain in the right shoulder
- ☐ M25.552- Pain in Left Hip
- ☐ M25.551- Pain in Right Hip
- ☒ M25.532- Pain in left wrist
- ☒ M25.531 - Pain in right wrist
- ☐ M19.072- Osteoarthritis Left Ankle
- ☐ M19.071- Osteoarthritis Right Ankle
- ☒ M25.522 Pain in left elbow
- ☒ M25.521 Pain in right elbow
- ☐ M54.2- Cervicalgia Pain in Neck

Length of Need: ☒ 12+ months (long term) ☐ _____ # of months (1-11)


DV MEDICAL SUPPLY

MEDICAL HISTORY**Previous treatments: TAKING MEDICATION**

Doctor's Notes: The patient reports chronic **RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST** pain for **A MONTH**. Patient states pain is **SHARP** with a pain scale of **6** and pain worsens with movements. Pain is caused by **ARTHRITIS** and is experienced **SOMETIMES**. 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: JEAN ROBERT DARBOUZE, MD DATE: 09-29-2024

Patient Name: **CAROL GARRISON**
Patient Address: **412 UNION ST APT 1 JERSEY CITY NJ 07304**
Patient Phone: **2019939702**

Physician Name: **JEAN ROBERT DARBOUZE, MD**
Address: 230 BERGEN AVE JERSEY CITY NJ 07305
Telephone: 2014320809
Fax: 2014320074

Patient: **CAROL GARRISON**
Date of Birth: **12/03/1956**
Visit Date: **WITHIN 12 MONTHS**
Reason for visit: **REGULAR CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	CAROL GARRISON	Date of Birth:	12/03/1956
Age:	67	Phone Number:	2019939702
Address:	412 UNION ST APT 1	City:	JERSEY CITY
State:	NJ	Zip Code:	07304
Gender:	FEMALE	Height:	5'7
Weight:	289	Waist Size	2XL

Patient Insurance

Provider:	MEDICARE	Member ID:	7GP3UX7CX60
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Medications

Current Medication	TYLENOL AS NEEDED
Medical History	HIGH BLOOD PRESSURE, DIABETES

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 MONTH
The surgery addressed the following: NA
The pain is experienced SOMETIMES
The patient has attempted the following previous treatments/therapies: TAKING MEDICATION
The patient described their pain as the following: SHARP
The activities that make the patient's pain worse is as follows: DOING DAILY ACTIVITIES
The pain is located in the patient's RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST
The patient's pain is caused by ARTHRITIS
The last time the patient has seen the doctor was on WITHIN 12 MONTHS

Chief Complaint

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

The patient reports chronic RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST pain for A MONTH. Patient states pain is SHARP with a pain scale of 6 and pain worsens with movement. The pain is caused by ARTHRITIS and is experienced SOMETIMES. 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 A MONTH located in their RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST related to M25.522 Pain in left elbow, M25.521 Pain in right elbow, 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 SHARP and occurs SOMETIMES. 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: DOING DAILY ACTIVITIES. Patient needs a RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST Brace to provide support and reduce pain level.

DV MEDICAL SUPPLY

Plan & Treatment Goals

Based on my evaluation of the patient's condition, I am ordering the following device(s) **L3761: ELBOW ORTHOSIS (EO), WITH ADJUSTABLE POSITION LOCKING JOINT(S), 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)

M25.522 Pain in left elbow, M25.521 Pain in right elbow, 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: **JEAN ROBERT DARBOUZE, MD**

Address: **230 BERGEN AVE JERSEY CITY NJ 07305**

Physician's Signature:



Date:

09-29-2024

Patient Name: **CAROL GARRISON**

Patient Address: **412 UNION ST APT 1 JERSEY CITY NJ 07304**

Patient Phone: **2019939702**

DV MEDICAL SUPPLY

LETTER OF MEDICAL NECESSITY

Re: **CAROL GARRISON**
Orthotic Device Need Assessment
Exam Date: **09/24/2024**
Height: **5'7**
Weight: **289**
DOB: **12/03/1956**

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

Ms GARRISON reports chronic **RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST** pain for **A MONTH**. Patient states pain is **SHARP** with a pain scale of 6 and pain worsens with **DOING DAILY ACTIVITIES**. Pain is experienced **SOMETIMES**. Previous treatments with heat, ice, medication and rest have been unsuccessful to control pain levels.

Diagnosis includes: **M25.522 Pain in left elbow, M25.521 Pain in right elbow, M25.532- Pain in left wrist, M25.531- Pain in right wrist**. Based on my conversation with **Ms GARRISON** and evaluation of his/her condition, I am ordering the following: **L3761: ELBOW ORTHOSIS (EO), WITH ADJUSTABLE POSITION LOCKING JOINT(S), 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 **RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST** requiring stabilization for improvement of functionality. I am prescribing this **WRIST, ELBOW** orthosis for the following indication(s): to aid when the patient is **DOING DAILY ACTIVITIES**, to aid in stabilization of the **WRIST, ELBOW**. My treatment goal(s) for the use of the prescribed **WRIST, ELBOW** 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 GARRISON** 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 GARRISON** continue medical follow-up as part of an ongoing plan of care.

Re: **CAROL GARRISON**..... DOB: **December 03, 1956**

I, **JEAN ROBERT DARBOUZE, 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.


JEAN ROBERT DARBOUZE, MD
Signature

Date Signed: 09-29-2024