

DV 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
BURNS	BARBARA		
LAST NAME	FIRST NAME	MI	
FEMALE	05/15/1943	8649638092	
GENDER	DATE OF BIRTH	PHONE NUMBER	
208 HATTERAS LN 2	SIMPSONVILLE	SC 29680	
ADDRESS	CITY	STATE & ZIPCODE	

INSURANCE INFORMATION	
MEDICARE	
PRIMARY INSURANCE	SECONDARY INSURANCE
6V49P36JC44	
MEMBER ID	MEMBER ID

PHYSICIAN INFORMATION	
JENNIFER ELLIS, MD	1083641757
PHYSICIAN NAME	NPI #
	864-522-5400
	PHONE NUMBER
717 SE MAIN ST SIMPSONVILLE SC 29681	864-522-5405
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"/> 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 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 checked="" type="checkbox"/> L3761 – Elbow Brace (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Size: MEDIUM) <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"/> 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 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 checked="" type="checkbox"/> M25.522 Pain in left elbow <input checked="" 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)	

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 **2 YEARS**. Patient states pain is **ACHY** with a pain scale of **7** 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: 

JENNIFER ELLIS, MD

PHYSICIAN NAME: _____

DATE: _____

08-31-2024

Patient Name: **BARBARA BURNS**
Patient Address: **208 HATTERAS LN 2 SIMPSONVILLE SC 29680**
Patient Phone: **8649638092**

Physician Name: **JENNIFER ELLIS, MD**
Address: 717 SE MAIN ST SIMPSONVILLE SC 29681
Telephone: 864-522-5400
Fax: 864-522-5405

Patient: **BARBARA BURNS**
Date of Birth: **05/15/1943**
Visit Date: **WITHIN A YEAR**
Reason for visit: **REGULAR CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	BARBARA BURNS	Date of Birth:	05/15/1943
Age:	81	Phone Number:	8649638092
Address:	208 HATTERAS LN 2	City:	SIMPSONVILLE
State:	SC	Zip Code:	29680
Gender:	FEMALE	Height:	6'2
Weight:	160	Waist Size	M

Patient Insurance

Provider:	MEDICARE	Member ID:	6V49P36JC44
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Medications

Current Medication	NONE
Medical History	NONE

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 7
The patient's pain started on or around 2 YEARS
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: ACHY
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 A YEAR

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 2 YEARS. Patient states pain is ACHY with a pain scale of 7 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.
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Objective of Assessment (Review of Symptoms)

Patient has chronic pain for 2 YEARS 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 ACHY and occurs SOMETIMES. The patient rated their pain on a scale of 1-10 (10 being the worst) on a level 7. 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: JENNIFER ELLIS, MD

Address: 717 SE MAIN ST SIMPSONVILLE SC 29681

Physician's Signature:



08-31-2024

Date:

Patient Name: BARBARA BURNS

Patient Address: 208 HATTERAS LN 2 SIMPSONVILLE SC 29680

Patient Phone: 8649638092

DV MEDICAL SUPPLY

LETTER OF MEDICAL NECESSITY

Re: **BARBARA BURNS**
Orthotic Device Need Assessment
Exam Date: **08/31/2024**
Height: **6'2**
Weight: **160**
DOB: **05/15/1943**

Ms BURNS 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 BURNS reports chronic **RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST** pain for **2 YEARS**. Patient states pain is **ACHY** with a pain scale of 7 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 BURNS** 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 BURNS** 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 BURNS** continue medical follow-up as part of an ongoing plan of care.

Re: **BARBARA BURNS**..... DOB: **May 15, 1943**

I, **JENNIFER ELLIS, 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.


JENNIFER ELLIS, MD
Signature

Date Signed:

08-31-2024