

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
HARRIS	JEANETTE		
LAST NAME	FIRST NAME	MI	
FEMALE	11/01/1942	8566307892	
GENDER	DATE OF BIRTH	PHONE NUMBER	
400 GRIMES RD, UNIT 110	SICKLERVILLE	NJ 08081	
ADDRESS	CITY	STATE & ZIPCODE	

INSURANCE INFORMATION	
MEDICARE	
PRIMARY INSURANCE	SECONDARY INSURANCE
8TR6MK6NF75	
MEMBER ID	MEMBER ID

PHYSICIAN INFORMATION	
ANDREW BLUMENTHAL DO	1962426338
PHYSICIAN NAME	NPI #
	8567511777
	PHONE NUMBER
805 COOPER RD SUITE 3 VOORHEES NJ 08043	8567518090
PRACTICE LOCATION	FAX NUMBER

PRESCRIPTION SELECTION	
<input checked="" type="checkbox"/> L3670 – Shoulder Brace (Side: <input checked="" type="checkbox"/> L <input type="checkbox"/> R) (Size: SMALL) <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: SMALL) <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 type="checkbox"/> L3916 – Wrist Hand Finger (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L3915 – Wrist Hand Finger (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 checked="" type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size:) <input type="checkbox"/> L1971 – Ankle Brace (Side: <input checked="" 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 checked="" 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 type="checkbox"/> M25.532- Pain in left wrist <input 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 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 **LOWER BACK, LEFT SHOULDER** pain for **MORE THAN A YEAR**. Patient states pain is **ACHY** with a pain scale of **8** 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: **ANDREW BLUMENTHAL DO** DATE: 09-03-2024

ADDICKS MEDICAL SUPPLY

Patient Name: **JEANETTE HARRIS**
Patient Address: **400 GRIMES RD UNIT 110 SICKLERVILLE NJ 08081**
Patient Phone: **8566307892**

Physician Name: **ANDREW BLUMENTHAL DO**
Address: 805 COOPER RD SUITE 3 VOORHEES NJ 08043
Telephone: 8567511777
Fax: 8567518090

Patient: **JEANETTE HARRIS**
Date of Birth: **11/01/1942**
Visit Date: **WITHIN A YEAR**
Reason for visit: **REGULAR CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	JEANETTE HARRIS	Date of Birth:	11/01/1942
Age:	81	Phone Number:	8566307892
Address:	400 GRIMES RD, UNIT 110	City:	SICKLERVILLE
State:	NJ	Zip Code:	08081
Gender:	FEMALE	Height:	5'6
Weight:	111	Waist Size	S

Patient Insurance

Provider:	MEDICARE	Member ID:	8TR6MK6NF75
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Medications

Current Medication	BUPROPION, PANTORPRAZOLE, LISINOPRIL
Medical History	HIGH BLOOD PRESSURE

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 8
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: ACHY
The activities that make the patient's pain worse is as follows: WALKING
The pain is located in the patient's LOWER BACK, LEFT SHOULDER
The patient's pain is caused by WEAR AND TEAR
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): LOWER BACK, LEFT SHOULDER

Subjective Notes

The patient reports chronic LOWER BACK, LEFT SHOULDER pain for MORE THAN A YEAR. Patient states pain is ACHY with a pain scale of 8 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 LOWER BACK, LEFT SHOULDER related to M54.50- Low back pain, unspecified, M25.512-Pain in the left shoulder. 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 8. The following activities make the patient's pain worse: WALKING. Patient needs a LOWER BACK, LEFT SHOULDER 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), L3670 SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), 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, M25.512-Pain in the left shoulder

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: **ANDREW BLUMENTHAL DO**

Address: **805 COOPER RD SUITE 3 VOORHEES NJ 08043**

Physician's Signature:



Date:

09-03-2024

Patient Name: **JEANETTE HARRIS**

Patient Address: **400 GRIMES RD UNIT 110 SICKLERVILLE NJ 08081**

Patient Phone: **8566307892**

ADDICKS MEDICAL SUPPLY

LETTER OF MEDICAL NECESSITY

Re: **JEANETTE HARRIS**
Orthotic Device Need Assessment
Exam Date: **08/31/2024**
Height: **5'6**
Weight: **111**
DOB: **11/01/1942**

Ms HARRIS is inquiring about utilizing orthotic bracing for his/her current conditions. His/her chief complaint at the time of this assessment is: **LOWER BACK, LEFT SHOULDER**.

Ms HARRIS reports chronic **LOWER BACK, LEFT SHOULDER** pain for **MORE THAN A YEAR**. Patient states pain is **ACHY** with a pain scale of **8** 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: **M54.50- Low back pain, unspecified, M25.512-Pain in the left shoulder**. Based on my conversation with **Ms HARRIS** 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), L3670 SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, OFF-THE-SHELF**.

Patient is ambulatory and has weakness of the **LOWER BACK, LEFT SHOULDER** requiring stabilization for improvement of functionality. I am prescribing this **BACK AND SHOULDER** orthosis for the following indication(s): to aid when the patient is **WALKING**, to aid in stabilization of the **BACK AND SHOULDER**. My treatment goal(s) for the use of the prescribed **BACK AND SHOULDER** 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 HARRIS** 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 HARRIS** continue medical follow-up as part of an ongoing plan of care.

Re: **JEANETTE HARRIS..... DOB: November 01, 1942**

I, **ANDREW BLUMENTHAL DO**, 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.


ANDREW BLUMENTHAL DO
Signature

Date Signed: **09-03-2024**