

FIRST STEP DME INC.

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
DIBONA _____ LAST NAME	CAMILLE _____ FIRST NAME	_____ MI	
FEMALE _____ GENDER	04/07/1950 _____ DATE OF BIRTH	9147795326 _____ PHONE NUMBER	
10 CROSS ST _____ ADDRESS	BRONXVILLE _____ CITY	NY 10708 _____ STATE & ZIPCODE	
INSURANCE INFORMATION			
MEDICARE _____ PRIMARY INSURANCE		SECONDARY INSURANCE _____ MEMBER ID	
8GM5JH5RG53 _____ MEMBER ID			
PHYSICIAN INFORMATION			
THOMAS CAMISA, MD _____ PHYSICIAN NAME		1467483149 _____ NPI #	
685 WHITE PLAINS RD EASTCHESTER NY 10709 _____ PRACTICE LOCATION		9147874100 _____ PHONE NUMBER	
		9147874199 _____ 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"/> L3180 – 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)	

FIRST STEP DME INC.

MEDICAL HISTORY

Previous treatments: SALT, WARM WATER AND TAKING ASPIRIN

Doctor's Notes: The patient reports chronic **LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW** pain for **2 MONTHS**. Patient states pain is **ACHY** with a pain scale of **10** and pain worsens with movements. Pain is caused by **WEAR AND TEAR** 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: 

THOMAS CAMISA, MD

PHYSICIAN NAME: _____

DATE: 

FIRST STEP DME INC.

Patient Name: CAMILLE DIBONA
Patient Address: 10 CROSS ST BRONXVILLE NY 10708
Patient Phone: 9147795326

Physician Name: THOMAS CAMISA, MD
Address: 685 WHITE PLAINS RD EASTCHESTER NY 10709
Telephone: 9147874100
Fax: 9147874199

Patient: CAMILLE DIBONA
Date of Birth: 04/07/1950
Visit Date: 01/29/2024
Reason for visit: CHECK-UP

Clinical Summary

Patient Demographics

Patient Name:	CAMILLE DIBONA	Date of Birth:	04/07/1950
Age:	74	Phone Number:	9147795326
Address:	10 CROSS ST	City:	BRONXVILLE
State:	NY	Zip Code:	10708
Gender:	FEMALE	Height:	5'0
Weight:	152	Waist Size	38

Patient Insurance

Provider:	MEDICARE	Member ID:	8GM5JH5RG53
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Medications

Current Medication	ASPIRIN (2X A DAY)
Medical History	NONE

Medical Diagnosis

The pain level was indicated on a scale of 1-10 as the following: 10
The patient's pain started on or around 2 MONTHS
The surgery addressed the following: NA
The pain is experienced SOMETIMES
The patient has attempted the following previous treatments/therapies: SALT, WARM WATER, AND TAKING ASPIRIN
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 LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW
The patient's pain is caused by WEAR AND TEAR
The last time the patient has seen the doctor was on 01/29/2024

Chief Complaint

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

Subjective Notes

The patient reports chronic LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW pain for 2 MONTHS. Patient states pain is ACHY with a pain scale of 10 and pain worsens with movement. The pain is caused by WEAR AND TEAR 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 2 MONTHS located in their LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW related to M25.532- Pain in left wrist, M25.531- Pain in right wrist, M25.522 Pain in left elbow, M25.521 Pain in right elbow. 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 10. The following activities make the patient's pain worse: DOING DAILY ACTIVITIES. Patient needs a LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW Brace to provide support and reduce pain level.
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FIRST STEP DME INC.

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), L3761: ELBOW ORTHOSIS (EO), WITH ADJUSTABLE POSITION LOCKING JOINT(S), 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 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)

M25.532- Pain in left wrist, M25.531- Pain in right wrist, M25.522 Pain in left elbow, M25.521 Pain in right elbow

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: **THOMAS CAMISA, MD**

Address: **685 WHITE PLAINS RD EASTCHESTER NY 10709**

Physician's Signature:

Date: **04/25/24**



Patient Name: **CAMILLE DIBONA**

Patient Address: **10 CROSS ST BRONXVILLE NY 10708**

Patient Phone: **9147795326**

FIRST STEP DME INC.

LETTER OF MEDICAL NECESSITY

Re: **CAMILLE DIBONA**
Orthotic Device Need Assessment
Exam Date: **04/22/2024**
Height: **5'0**
Weight: **152**
DOB: **04/07/1950**

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

Ms DIBONA reports chronic **LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW** pain for **2 MONTHS**. Patient states pain is **ACHY** with a pain scale of **10** 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: **M25.532- Pain in left wrist, M25.531- Pain in right wrist, M25.522 Pain in left elbow, M25.521 Pain in right elbow**. Based on my conversation with **Ms DIBONA** 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), L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF), L3761: ELBOW ORTHOSIS (EO), WITH ADJUSTABLE POSITION LOCKING JOINT(S), PREFABRICATED, OFF-THE-SHELF**.

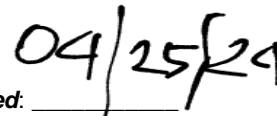
Patient is ambulatory and has weakness of the **LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW** requiring stabilization for improvement of functionality. I am prescribing this **LEFT WRIST, RIGHT WRIST, RIGHT ELBOW AND LEFT ELBOW** orthosis for the following indication(s): to aid when the patient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

Re: **CAMILLE DIBONA..... DOB: APRIL 07, 1950**

I, **THOMAS CAMISA, 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.


THOMAS CAMISA, MD
Signature


Date Signed: _____