

GLOBAL MEDICAL EQUIPMENT

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
DUBROVSKY	ARLENE		
LAST NAME	FIRST NAME	MI	
FEMALE	01/30/39	7326186454	
GENDER	DATE OF BIRTH	PHONE NUMBER	
22 COOPER AVE, UNIT 409	LONG BRANCH	NJ 07740	
ADDRESS	CITY	STATE & ZIPCODE	

INSURANCE INFORMATION	
MEDICARE	
PRIMARY INSURANCE	SECONDARY INSURANCE
3VY7CD5FE71	
MEMBER ID	MEMBER ID

PHYSICIAN INFORMATION	
SHERIF MALEK, MD	1699716175
PHYSICIAN NAME	NPI #
	7322226637
232 NORWOOD AVE W LONG BRANCH NJ 07764	PHONE NUMBER
PRACTICE LOCATION	7322226645
	FAX NUMBER

PRESCRIPTION SELECTION	
<input type="checkbox"/> L3671 – 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 checked="" type="checkbox"/> L3670 – Shoulder Brace (Side: <input checked="" type="checkbox"/> L <input type="checkbox"/> R) (Size: SMALL) <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"/> 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 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 neck
Length of Need: <input checked="" type="checkbox"/> 12+ months (long term) <input type="checkbox"/> ____ # of months (1-11)	

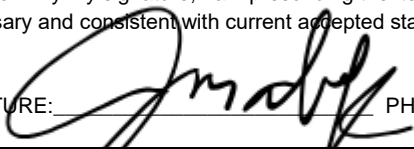
MEDICAL HISTORY

Previous treatments: RESTING

Doctor's Notes: The patient reports chronic **Back, Left Shoulder** pain for **OVER A YEAR**. Patient states pain is **ACHY** with a pain scale of **8** and pain worsens with movements. Pain is caused by **ARTHRITIS** and is experienced **DAILY**. 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: SHERIF MALEK, MD DATE: 10/05/2024

GLOBAL MEDICAL EQUIPMENT

Patient Name: **ARLENE DUBROVSKY**
Patient Address: **22 COOPER AVE, UNIT 409 LONG BRANCH NJ 07740**
Patient Phone: **7326186454**

Physician Name: **SHERIF MALEK, MD**
Address: **232 NORWOOD AVE W LONG BRANCH NJ 07764**
Telephone: **7322226637**
Fax: **7322226645**

Patient: **ARLENE DUBROVSKY**
Date of Birth: **01/30/39**
Visit Date: **A MONTH AGO**
Reason for visit: **Check-up**

Clinical Summary

Patient Demographics

Patient Name:	ARLENE DUBROVSKY	Date of Birth:	01/30/39
Age:	85	Phone Number:	7326186454
Address:	22 COOPER AVE, UNIT 409	City:	LONG BRANCH
State:	NJ	Zip Code:	07740
Gender:	FEMALE	Height:	5'0
Weight:	107	Waist Size	S

Patient Insurance

Provider:	MEDICARE	Member ID:	3VY7CD5FE71
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Resting

Current Medication	TYLENOL
Medical History	NONE

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 OVER A YEAR
The surgery addressed the following: NA
The pain is experienced SOMETIMES
The patient has attempted the following previous treatments/therapies: RESTING
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 Back, Left Shoulder
The patient's pain is caused by ARTHRITIS
The last time the patient has seen the doctor was on A MONTH AGO

Chief Complaint

The patient's main complaint is that they experience chronic pain located in the following location(s): Back, Left Shoulder
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Subjective Notes

The patient reports chronic Back, Left Shoulder pain for OVER A YEAR . Patient states pain is ACHY with a pain scale of 8 and pain worsens with movement. The pain is caused by ARTHRITIS and is experienced DAILY . 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 OVER A YEAR located in their 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 DAILY . 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: PERFORMING DAILY ACTIVITIES . Patient needs a Back, Left Shoulder Brace to provide support and reduce pain level.

GLOBAL MEDICAL EQUIPMENT

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 resting, 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 arthritis 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 arthritis 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: **SHERIF MALEK, MD**

Address: **232 NORWOOD AVE W LONG BRANCH NJ 07764**

Physician's Signature:



Date:

10/05/2024

Patient Name: **ARLENE DUBROVSKY**

Patient Address: **22 COOPER AVE, UNIT 409 LONG BRANCH NJ 07740**

Patient Phone: **7326186454**

GLOBAL MEDICAL EQUIPMENT

LETTER OF MEDICAL NECESSITY

Re: **ARLENE DUBROVSKY**
Orthotic Device Need Assessment
Exam Date: **10/04/2024**
Height: **5'0**
Weight: **107**
DOB: **01/30/39**

Ms DUBROVSKY is inquiring about utilizing orthotic bracing for his/her current conditions. His/her chief complaint at the time of this assessment is: **Back, Left Shoulder**.

Ms DUBROVSKY reports chronic **Back, Left Shoulder** pain for **Months**. Patient states pain is **ACHY** with a pain scale of **8** and pain worsens with **PERFORMING DAILY ACTIVITIES**. Pain is experienced **DAILY**. Previous treatments with heat, ice, medication and rest have been unsuccessful to control pain levels.

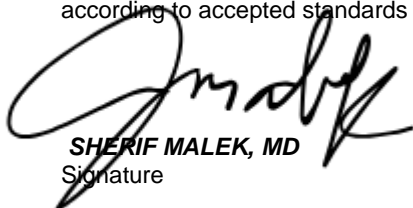
Diagnosis includes: **M54.50- Low back pain, unspecified, M25.512-Pain in the left shoulder**. Based on my conversation with **Ms DUBROVSKY** and evaluation of his/her condition, I am ordering the following: **L0457 (TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT 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 **Back, Left Shoulder** requiring stabilization for improvement of functionality. I am prescribing this **Back, Left Shoulder** orthosis for the following indication(s): to aid when the patient is **PERFORMING DAILY ACTIVITIES**, to aid in stabilization of the **Back, Left Shoulder**. My treatment goal(s) for the use of the prescribed **Back, Left 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 DUBROVSKY** 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 DUBROVSKY** continue medical follow-up as part of an ongoing plan of care.

Re: **ARLENE DUBROVSKY**..... DOB: **January 30, 1939**

I, **SHERIF MALEK, 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.


SHERIF MALEK, MD
Signature

Date Signed: 10/05/2024