

GLOBAL MEDICAL EQUIPMENT

RX / MEDICAL NECESSITY FORM

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|----------------------------|-------------------|-------------------|--|
| PATIENT INFORMATION | | | SHIPPING METHOD: <input checked="" type="checkbox"/> SHIP TO PATIENT'S HOME ADDRESS <input type="checkbox"/> SHIP TO PATIENT'S PHYSICIAN CLINIC |
| VISKER | ALICE | | |
| LAST NAME | FIRST NAME | MI | |
| FEMALE | 08/31/1942 | 5305203334 | |
| GENDER | DATE OF BIRTH | PHONE NUMBER | |
| 155 LIVE OAK ST | AUBURN | CA 95603 | |
| ADDRESS | CITY | STATE & ZIPCODE | |

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| INSURANCE INFORMATION | |
| MEDICARE | |
| PRIMARY INSURANCE | SECONDARY INSURANCE |
| 5EM9NQ3TE21 | |
| MEMBER ID | MEMBER ID |

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| PHYSICIAN INFORMATION | |
| GORDON MARLER, D.O. | 1366738825 |
| PHYSICIAN NAME | NPI # |
| | 5308853951 |
| | PHONE NUMBER |
| 13555 BOWMAN RD # 100 AUBURN CA 95603 | 5308853932 |
| PRACTICE LOCATION | FAX NUMBER |

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| PRESCRIPTION SELECTION | |
| <input type="checkbox"/> L3670 – Shoulder Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <input type="checkbox"/> L3670 – 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 type="checkbox"/> L3761 – Elbow Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Size:) <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"/> L1833 / L1851 – 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 checked="" type="checkbox"/> L1906 – Ankle Brace (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) (Shoe Size: 7) <input type="checkbox"/> L1971 – Ankle Brace (Side: <input type="checkbox"/> L <input type="checkbox"/> R) (Shoe Size:) <input type="checkbox"/> L0174 – Cervical Brace <input checked="" type="checkbox"/> L3170 – Heel Stabilizer (Side: <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> R) |

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| 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 checked="" type="checkbox"/> M19.072- Osteoarthritis Left Ankle <input checked="" 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) | |

MEDICAL HISTORY

Previous treatments: TAKING MEDICATION

Doctor's Notes: The patient reports chronic **LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST** pain for **SEVERAL YEARS**. Patient states pain is **SHARP** 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: _____ PHYSICIAN NAME: **GORDON MARLER, D.O.** DATE: _____



10-07-2024

GLOBAL MEDICAL EQUIPMENT

Patient Name: **ALICE VISKER**
Patient Address: **155 LIVE OAK ST AUBURN CA 95603**
Patient Phone: **5305203334**

Physician Name: **GORDON MARLER, D.O.**
Address: 13555 BOWMAN RD # 100 AUBURN CA 95603
Telephone: 5308853951
Fax: 5308853932

Patient: **ALICE VISKER**
Date of Birth: **08/31/1942**
Visit Date: **09/23/2024**
Reason for visit: **REGULAR CHECK-UP**

Clinical Summary

Patient Demographics

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|---------------|-----------------|----------------|------------|
| Patient Name: | ALICE VISKER | Date of Birth: | 08/31/1942 |
| Age: | 82 | Phone Number: | 5305203334 |
| Address: | 155 LIVE OAK ST | City: | AUBURN |
| State: | CA | Zip Code: | 95603 |
| Gender: | FEMALE | Height: | 5'1 |
| Weight: | 145 | Waist Size | L |

Patient Insurance

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| Provider: | MEDICARE | Member ID: | 5EM9NQ3TE21 |
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Medications

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| Current Medication | TYLENOL |
| Medical History | HIGH BLOOD PRESSURE |

Medical Diagnosis

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| The pain level was indicated on a scale of 1-10 as the following: 7 |
| The patient's pain started on or around SEVERAL YEARS AGO |
| 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: WALKING |
| The pain is located in the patient's LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST |
| The patient's pain is caused by ARTHRITIS |
| The last time the patient has seen the doctor was on 09/23/2024 |

Chief Complaint

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

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| The patient reports chronic LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST pain for SEVERAL YEARS. Patient states pain is SHARP 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)

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| Patient has chronic pain for SEVERAL YEARS located in their LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST related to M19.071- Osteoarthritis Right Ankle, M19.072- Osteoarthritis Left Ankle, 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 7. The following activities make the patient's pain worse: WALKING. Patient needs a LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST 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) **L3916 (WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF), L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF INCLUDES L3170 HEEL STABILIZER** 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)

M19.071- Osteoarthritis Right Ankle, M19.072- Osteoarthritis Left Ankle, 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: **GORDON MARLER, D.O.**

Address: **13555 BOWMAN RD # 100 AUBURN CA 95603**

Physician's Signature:



Date:

10-07-2024

Patient Name: **ALICE VISKER**

Patient Address: **155 LIVE OAK ST AUBURN CA 95603**

Patient Phone: **5305203334**

GLOBAL MEDICAL EQUIPMENT

LETTER OF MEDICAL NECESSITY

Re: **ALICE VISKER**
Orthotic Device Need Assessment
Exam Date: **10/05/2024**
Height: **5'1**
Weight: **145**
DOB: **08/31/1942**

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

Ms VISKER reports chronic **LEFT ANKLE, RIGHT ANKLE, LEFT WRIST, RIGHT WRIST** pain for **SEVERAL YEARS**. Patient states pain is **SHARP** with a pain scale of 7 and pain worsens with **WALKING**. Pain is experienced **SOMETIMES**. Previous treatments with heat, ice, medication and rest have been unsuccessful to control pain levels.

Diagnosis includes: **M19.071- Osteoarthritis Right Ankle, M19.072- Osteoarthritis Left Ankle, M25.532- Pain in left wrist, M25.531- Pain in right wrist**. Based on my conversation with **Ms VISKER** 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), L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF INCLUDES L3170 HEEL STABILIZER**.

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

Re: **ALICE VISKER**..... DOB: **August 31, 1942**

I, **GORDON MARLER, D.O.**, 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.


GORDON MARLER, D.O.
Signature

Date Signed: **10-07-2024**