

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
HAMMERBECK	ALLAN		
LAST NAME	FIRST NAME	MI	
MALE	09/14/36	8645950655	
GENDER	DATE OF BIRTH	PHONE NUMBER	
539 BRIDGEFORD LN	MOORE	SC 29369	
ADDRESS	CITY	STATE & ZIPCODE	

INSURANCE INFORMATION	
MEDICARE	
PRIMARY INSURANCE	SECONDARY INSURANCE
6M44Q09HP03	
MEMBER ID	MEMBER ID

PHYSICIAN INFORMATION	
DAVID CYKERT, MD	1154777456
PHYSICIAN NAME	NPI #
	8645609056
	PHONE NUMBER
1650 SKYLYN DR #220, SPARTANBURG, SC 29307	8645609057
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)	

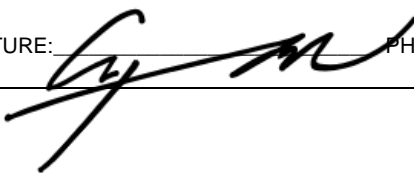
MEDICAL HISTORY

Previous treatments: TAKING MEDICATION

Doctor's Notes: The patient reports chronic **RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST** pain for **MORE THAN A YEAR**. Patient states pain is **ACHY, SHARP** with a pain scale of **7** 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: 

PHYSICIAN NAME: DAVID CYKERT, MD

DATE: 09-18-2024

Patient Name: **ALLAN HAMMERBECK**
Patient Address: **539 BRIDGEFORD LN MOORE SC 29369**
Patient Phone: **8645950655**

Physician Name: **DAVID CYKERT, MD**
Address: **1650 SKYLYN DR #220, SPARTANBURG, SC 29307**
Telephone: **8645609056**
Fax: **8645609057**

Patient: **ALLAN HAMMERBECK**
Date of Birth: **09/14/36**
Visit Date: **3-4 MONTHS AGO**
Reason for visit: **REGULAR CHECK-UP**

Clinical Summary

Patient Demographics

Patient Name:	ALLAN HAMMERBECK	Date of Birth:	09/14/36
Age:	88	Phone Number:	8645950655
Address:	539 BRIDGEFORD LN	City:	MOORE
State:	SC	Zip Code:	29369
Gender:	MALE	Height:	5.2
Weight:	147	Waist Size	M

Patient Insurance

Provider:	MEDICARE	Member ID:	6M44Q09HP03
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Medications

Current Medication	TYLENOL AS NEEDED
Medical History	HIGH BLOOD PRESSURE

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 MORE THAN A YEAR
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, SHARP
The activities that make the patient's pain worse is as follows: WALKING
The pain is located in the patient's RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST
The patient's pain is caused by WEAR AND TEAR
The last time the patient has seen the doctor was on 3-4 MONTHS AGO

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

Subjective Notes

The patient reports chronic RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST pain for MORE THAN A YEAR . Patient states pain is ACHY, SHARP with a pain scale of 7 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 MORE THAN A YEAR 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, 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 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: DAVID CYKERT, MD

Address: 1650 SKYLYN DR #220, SPARTANBURG, SC 29307

Physician's Signature:



09-18-2024

Date:

Patient Name: ALLAN HAMMERBECK

Patient Address: 539 BRIDGEFORD LN MOORE SC 29369

Patient Phone: 8645950655

DV MEDICAL SUPPLY

LETTER OF MEDICAL NECESSITY

Re: **ALLAN HAMMERBECK**
Orthotic Device Need Assessment
Exam Date: **09/17/2024**
Height: **5.2**
Weight: **147**
DOB: **09/14/36**

Mr HAMMERBECK 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**.

Mr HAMMERBECK reports chronic **RIGHT ELBOW, LEFT ELBOW, RIGHT WRIST, LEFT WRIST** pain for **MORE THAN A YEAR**. Patient states pain is **ACHY, 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: **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 **Mr HAMMERBECK** 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 **WALKING**, 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. **Mr HAMMERBECK** has been provided a phone number to call if there are any additional comments or questions regarding this examination, and I have recommended that **Mr HAMMERBECK** continue medical follow-up as part of an ongoing plan of care.

Re: **ALLAN HAMMERBECK**..... DOB: **September 14, 1936**

I, **DAVID CYKERT, 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.


DAVID CYKERT, MD
Signature

Date Signed:

09-18-2024