BILLY H. FORD, MD, PC

bhfordmdpc@gmail.com

Patient: txtName|patientfullname
DOB: txtDOB|DOB
Provider: Billy Ford MD
Date: txtDate|ToDay

***DME Letter of Medical Necessity:**

Patient Information:

txtName2|patientfullname

txtAddress|fullAddress

Date of Birth: txtDOB2|DOB

Insurance: txtInsCo|InsCo
Policy #: txtCliamNo|ClaimOrPolicy_No

Medical Necessity Note:

I am requesting that Lumbar Sacral Orthosis be authorized for patient to utilize daily. Patient is experiencing pain, inflammation, and lower back instability. A lumbar sacral orthosis with a removable ice pack would aid in stability and pain reduction. I deem this medically necessary. Thank you.

RX for: Lumbar Sacral Orthosis w/ Ice Pack

Billy Ford, MD