|  |
| --- |
| **Advanced Medical Supply** |
| **Phone: 866-994-2583** |
| **Fax: 817-780-0212** |

**FAX**

**To:**

**Name: {{pcp\_name}}**

**Fax Number: {{pcp\_fax}}**

**From: no # pages: 2(including cover)**

**Name: Advanced Diabetic Supply**

**Fax Number: (817) 780-0212**

|  |
| --- |
| **Subject: {{name}}** |

|  |
| --- |
| **Message:**  **Please sign the prescription and return the fax along with the recent visit notes or the progress notes of the patient.**  **Thanks** |

**PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FOR BACK ORTHOSIS**

PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS Fax No: (**817) 780-0212**

|  |  |
| --- | --- |
| **Patient’s Information**  Date: {{date}}  Name:  **{{name}}**  Address: {{address}}, {{city}}, {{state}}, {{zip}}  Phone: {{phone}}  DOB: **{{dob}}**  Primary Ins: {{insurance}}  Policy #: **{{medicare}}**  Height: **{{height}}**  Weight: **{{weight}}** | **Physician Information**  Physician Name: **{{pcp\_name}}**  Address:{{pcp\_address}},{{pcp\_city}},{{pcp\_state}},{{pcp\_zip}}  Phone Number: {{pcp\_phone}}  Fax Number: {{pcp\_fax}}  NPI: **{{pcp\_npi}}** |

*This patient is being treated under a comprehensive plan of care for back pain.  
I, the undesigned; certify that the prescribed orthosis is medically necessary for the patient’s overall well-being.  
This patient has suffered an injury or undergone surgery. In my opinion, the following orthosis products are both  
reasonable and necessary in reference to treatment of the patient’s condition and/or rehabilitation. My patient  
has been in my care regarding the diagnosis below. This is treatment I see fit for this patient at this time. I  
certify that this information is true and correct.*

**DIAGNOSIS:** Provider can simply cut off the diagnosis which they don’t find appropriate

Lumbar/Lumbosacral Intervertebral Disc Degeneration (M51.36)  
 Other Intervertebral Disc Degeneration, Lumbosacral Region (M51.37)  
 Spinal Stenosis, Lumbar Region (M48.06)  
 Spinal Stenosis, Lumbosacral Region (M48.07)  
 Other Intervertebral Disc Disorders, Lumbosacral Region (M51.87)  
 Low Back Pain (M54.5)  
 Unspecified Osteoarthritis, Unspecified Site (M19.90)  
 Other/Explain (Include Code):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Our evaluation of the above patient has determined that following back pain orthosis product will benefit this patient***

**DISPENSE:**  
**L0637** LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR  
AND POSTERIOR FRAME/PANEL(S), POSTERIOS EXTENDS FROM SACROCOCCYGEAL  
JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL  
FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON  
INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PDDING, SHOULDER  
STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF  
Estimated length of need (# of months): \_\_\_\_\_\_\_ 6 – 99 (99=LIFETIME)

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated signed: \_\_\_\_\_\_\_\_\_