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

PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS Fax No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **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:  Address: {{pcp\_address}}, {{pcp\_city}}, {{pcp\_state}}, {{pcp\_zip}}  Phone Number: {{pcp\_phone}}  Fax Number: {{pcp\_fax}}  NPI: {{npi}} |

*This patient is being treated under a comprehensive plan of care for Elbow 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

Cubital Tunnel Syndrome (G56.2)  
 Rheumatoid Bursitis, left elbow (M06.222)  
 Rheumatoid bursitis, right elbow(M06.221)  
 Pain in left elbow (M25.521)  
 Pain in right elbow (M25.522  
 Unspecified sprain of left elbow (S53.402)  
 Unspecified sprain of right elbow (S53.401)  
 Disorder of ligament, left elbow (M24.222)  
 Disorder of ligament, right elbow (M24.221  
 Other/Explain (Include Code):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AFFECTED AREA:**

ELBOW: Left Right

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

**DISPENSE:**  
**L3761** Elbow orthosis (eo), with adjustable position locking joint(s), prefabricated, off-the-shelf Estimated length of need (#of months): 6 - 99 (99=LIFETIME)

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

Physician Name: {{pcp\_name}} NPI: {{npi}}