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| **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}}** |

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| **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 HIP ORTHOSIS**

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

|  |  |
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| **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 hip 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

Unilateral Primary Osteoarthritis, Right Hip (M16.11)  
 Unilateral Primary Osteoarthritis, Left Hip (M16.12)  
 Other/Explain (Include Code):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AFFECTED AREA:**

HIP: Left Right

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

**DISPENSE:**  
**L1690** COMBINATION, LUMBO-SACRAL, HIP, FEMUR ORTHOSIS PROVIDING ADDUCTION AND INTERNAL ROTATION CONTROL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

Estimated length of need (#of months): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6 - 99 (99=LIFETIME)

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

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