Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **Patient’s Information**  Name:  Address:  Phone:  DOB: Height: Weight:  Primary Ins:  Policy #: | **Physician Information**  Physician Name:  Address:  Phone Number:  Fax Number:  NPI: |

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| --- | --- |
| DEVICE ICD-10 DIAGNOSIS CODE | |
| **Shoulder Brace:** | HCPCS: L3960 - Other \_\_\_\_\_\_\_\_\_ RT LT BILATERAL |
| **M75.110** Incomplete Rotator Cuff Tear or Rupture of unspecific Shoulder, not specific at traumatic  **M75.111** Incomplete Rotator Cuff Tear or Rupture of right Shoulder, not specified at traumatic  **M75.112** Incomplete Rotator Cuff Tear or Rupture left Shoulder, not specified at traumatic  **M75.91** Shoulder lesion – unspecified Right | **M19.012** Primary Osteoarthritis Left S  **M19.011** Trauma Osteoarthritis Right S  **M19.019** Degenerative Joint Disease  **M75.20** Bicipital Tendinitis-Shoulder  **M75.92** Shoulder lesion – unspecified left  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- |
| **Reason for Brace:**  Increase ROM Avoidance of Surgery Facilitate Healing Following Injury  Decrease ROM Reduce Pain by Reducing Mobility Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **LENGTH OF NEED:** This order is good for a lifetime unless otherwise indicated by the Physician: \_\_\_\_\_\_\_\_\_\_ | |
| *By my signature below, I confirm that the patient has the medical condition(s) listed above and is being treated by me. The above information is true, accurate and complete to the best of my knowledge. I certify that the items/services listed above are medically necessary to treat this patient’s condition and accurately reflect the treatment regimen I have prescribed. My medical records for this patient substantiate the prescribed treatment plan. I certify that my patient and/or caregiver are capable of using these products safely and effectively. Per Medicare, Medicaid and other insurance requirements, I will maintain a copy of this order in the patient’s medical record. I agree to provide copies of all supporting medical records substantiating the medical necessity for the products ordered as requested for insurance review/audit purposes.* | |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NPI #: {{pcp\_npi}} Provider Print Name: {pcp\_name}} | |
| Please sign and send back: | Thank you for your business! |