|  |
| --- |
| **Advanced Medical Supply** |
| **Phone: 866-994-2583** |
| **Fax 1st: 469-501-9073**  **Fax 2nd: 817-780-0212** |

**FAX**

**To:**

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

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

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

**Name: Advanced Diabetic Supply**

**Fax Number: (469) 501-9073**

|  |
| --- |
| **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 WRIST ORTHOSIS

PLEASE FAX BACK TO US WITHIN 48-HOURS

FAX TO: (**817) 780-0212**

Date: {{date}}

|  |  |
| --- | --- |
| Patient: **{{name}}** | Physician: **{{pcp\_name}}** |
| DOB: **{{dob}}** Height: {{height}} Weight: {{weight}} | NPI: **{{pcp\_npi}}** |
| Address: {{address}}, {{city}}, {{state}}, {{zip}} | Address: {{pcp\_address}}, {{pcp\_city}}, {{pcp\_state}}, {{pcp\_zip}} |
| Phone Number: **{{phone}}** | Phone Number: **{{pcp\_phone}}** |
| Insurance: {{insurance}} Policy: **{{medicare}}** | Fax number: {{pcp\_fax}} |

**DIAGNOSIS:** ICD-10 (PROVIDER CAN SIMPLY CLEAR OUT DIAGNOSIS WHEN THEY DON’T FIND ACCURATE

M19.031 RT Primary Osteoarthritis, right wrist

M19.032 LT Primary Osteoarthritis, left wrist

Other/Explain (Include Code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DISPENSE** **EQUIPMENT DISCRIPTION**

**L3916** BI-WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF

Other/Explain (Include Code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPORTANT: RETURN WITH A COPY OF THE PATIENTS MEDICAL RECORD ASSOCIATED WITH THE REQUESTED PRODUCT**

I, THE UNDERSIGNED; CERTIFY THAT THE PRESCRIBED ORTHOSIS IS MEDICALLY NECESSARY FOR THE PATIENT’S OVERALL WELL-BEING. THIS PATIENT IS SUFFERING FROM PAIN AND IN MY OPINION, THE FOLLOWING ORTHOSIS PRODUCTS ARE BOTH REASONABLE AND NECESSARY IN REFERENCE TO TREATMENT OF THE PATIENT’S CONDITION AND/OR REHABILITATION. THE PATIENT HAS BEEN IN MY CARE REGARDING THE DIAGNOSIS BELOW. THIS IS THE TREATMENT I SEE FIT FOR THIS PATIENT AT THIS TIME. I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT.

Estimated length of need (# of months): 99 = LIFETIME, UNLESS OTHERWISE NOTED:

PHYSICIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN NAME: {{pcp\_name}} PHYSICIAN NPI: {{pcp\_npi}}