Physician Order Prescription, and Letter of Medical Necessity for Lumbar Orthosis (LO) or Lumbar Sacral Orthosis (LSO)

Patient Name: ______________________ Patient DOB: ______________________

Medicare #: ______________________ Patient Phone: ______________________

Treating Physician: ______________________

Physician Address: ______________ City: __________ State: ________ Zip: ________

Physician Phone: ______________ Physician Fax: ______________

INSTRUCTIONS: The above named patient has requested that you fill out this order form. Please complete the entire form and fax to the number below. Per Medicare guidelines, we are required to obtain progress notes along with this signed RX and qualifying diagnosis code(s) for product sought by your patient. Please make sure the supporting documentation is faxed to validate medical necessity in order to facilitate your patients' request. Unfortunately, without these necessary documents we will not be able to supply the product requested by your patient. This prescription also acts as the letter of Medical Necessity.

Item(s) to be ordered:

A lumbar-sacral orthosis _______ L0627 _______ L0631 OR _______ L0648

is covered when it is ordered for one of the following indications:

Please indicate which of the following conditions apply to the patient. Check all that apply.

___ To reduce pain by restricting mobility of the truck: or

___ To facilitate healing following an injury to the soine of related soft tissues: or

___ To facilitate healing following a surgical procedure on the spine or raltes soft tissue: or

___ To otherwise support weak spinal muscles and/or a deformed spine.

Please choose ICD-10:

____ Lumbago (M54.4)

____ Spinal Stenosis (M48.08)

____ Muscle Weakness (M62.81)

____ Spondylolisthesis (M43.16)

____ Lumbar Disc Displacement (M51.26)

____ Lumbosacral Sponsylosis (M47.817)

____ Lumbar Strains/Sprain (S33.5XXA)

____ Spinal Disorder (M43.8X9)

____ Lumbar / Lumbosacral Intervertebral (M51.37)

____ Disc Degeneration (M51.36)

____ Other ICD-10

Estimated Length of Need (# of months): ______________ (99 = Lifetime)

This patient is being treated under a comprehensive plan of care for arthritis/pain. I, the undersigned, certify that the above prescribed is medically necessary for the patients' overall well-being. In my opinion, the following orthotic/arthritic relief products are both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be made available upon request.

Physicians Signature: ______________ NPI#: ______________ Date: __________