

**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 trunk: or
- To facilitate healing following an injury to the spine or related soft tissues: or
- To facilitate healing following a surgical procedure on the spine or related soft tissue: or
- To otherwise support weak spinal muscles and/or a deformed spine.

**Please choose ICD-10:**

- |  |   |
|--|---|
| <input type="checkbox"/> Lumbago (M54.4)                   | <input type="checkbox"/> Lumbar Strains/Sprain (S33.5XXA)             |
| <input type="checkbox"/> Spinal Stenosis (M48.08)          | <input type="checkbox"/> Spinal Disorder (M43.8X9)                    |
| <input type="checkbox"/> Muscle Weakness (M62.81)          | <input type="checkbox"/> Lumbar / Lumbosacral Intervertebral (M51.37) |
| <input type="checkbox"/> Spondylolisthesis (M43.16)        | <input type="checkbox"/> Disc Degeneration (M51.36)                   |
| <input type="checkbox"/> Lumbar Disc Displacement (M51.26) | <input type="checkbox"/> Other ICD-10                                 |
| <input type="checkbox"/> Lumbosacral Spondylosis (M47.817) |   |

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/arthritis 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: \_\_\_\_\_