Physician Order, Prescription, and CMN for Lumbar-Sacral Orthosis (LSO)

Patient Name: _____ Patient DOB: _____

Insurance Info _____ 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 *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.

Item(s) to be ordered:

☐ **LO627** **(LO)** Lumbar Orthosis – Sagittal control with posterior support that extends from L-1 below L-5; Beneficial for multiple level decompression, laminectomy, posterior lateral fusion.

☐ **LO631** Passport / Premium Plus **(LSO)** Lumbar Sacral Orthosis – **Sagittal control** back brace with posterior support that extends from sacrococygeal junction to T-9 vertebra. Indicators included by not limited to; Degenerative and bulging discs, Herniatged/bulging discs, Spinal senosis, Spondylolisthesis, Facet syndrome, thoracolumbar injury, evision surgery, multi-level fusion. Lumbara sacral mechanical back pain.

☐ **LO637** Tri-Mod **(LSO)** Lumbar Sacral Orthosis – **Sagittal & coronal control** back brace with posterior support that extends from sacrococygeal junction to T-9 vertebra. Indicators included by not limited; Post-operative stabilization protocol following spinal fusion, laminectomy/laminotomy, foraminotomy, laproscopic disk replacement, IDET procedures. Multi-level decompression, Bust fractures, Chronic & mechanical low back pain.

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 or 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-9

☐ 716.9 Arthropathy	☐ 715.90 Osteoarthritis, Degenerative	☐ 714.00 Arthritis, Rheumatoid
☐ 719.50 Joint Stiffness	☐ 847.2 Lumbar Sprain/Strain	☐ 724.2 Chronic Low Back Pain
☐ 728.20 Disuse Atrophy	☐ 728.87 Muscle Weakness	☐ _____ Other ICD-9

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: _____

****PLEASE FAX THIS ORDER TO 718-921-4661****

Scarpa Pharmacy & Surgical Supplies

6220 11th Ave Brooklyn , NY 11219