PHYSICIANS WRITTEN DETAIL ORDER

Patient Name_____ Date_____

Address_____

Insurance ID Number_____ Date of Birth_____

Please indicate the V-Force Lumbar Brace prescribed for this patient:

- ☐ Flex (PDAC HCPCS Code L0637)
- ☐ RAZAR (PDAC HCPCS Code L0627)
- ☐ TLSO (PDAC HCPCS Code L0637)
- ☐ Transformer (PDAC HCPCS Code L0637)

Please indicate the applicable diagnosis/diagnoses for this patient:

- ☐ Degenerative Disc Disease (722.52)
- ☐ Herniated Lumbar Disc/HNP (722.10)
- ☐ Lumbar Facet Syndrome (724.8)
- ☐ Radiculopathy (724.4)
- ☐ Spondylosis/Osteoarthritis (721.3)
- ☐ Spondylolysis (756.11)
- ☐ Spondylolisthesis (756.12)
- ☐ Stenosis (724.02)

Please check the answers that apply to this patient:

- ☐ YES ☐ NO Does this patient have chronic back pain that can be reduced by restricting trunk mobility?
- ☐ YES ☐ NO Is the back brace needed to promote healing of an injury or surgery involving the spine?
- ☐ YES ☐ NO Is the back brace needed to support weak spinal muscles or a spinal deformity?

NOTE: The patient's medical record **must** contain sufficient documentation of the patient's medical condition to substantiate the necessity for the ordered brace. The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. Neither a physician's order, nor a supplier-prepared statement, nor a physician attestation by itself provides sufficient documentation of medical necessity, even though the treating physician or supplier signs it. There must be information in the patient's medical record that supports the medical necessity for the brace or information on a supplier-prepared statement or physician attestation.

I CERTIFY THAT THE EQUIPMENT I AM PRESCRIBING IS MEDICALLY NECESSARY FOR THIS PATIENT'S CONDITION. THE EQUIPMENT IS BOTH REASONABLE AND NECESSARY IN REFERENCE TO ACCEPTED STANDARDS OF MEDICAL PRACTICE TO TREAT THIS PATIENT'S CONDITION AND NOT PRESCRIBED AS "CONVENIENCE" EQUIPMENT.

Physician Name_____ NPI_____

Address_____

Phone_( )_____ Fax_( )_____

Physician Signature_____ Date_____