

# Prescription/SWO for Lumbar-Sacral Orthosis Back Support

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ NC: \_\_\_\_\_ ZIP: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Medicare/Insurance # \_\_\_\_\_

Treating Physician: \_\_\_\_\_

Physician Address: \_\_\_\_\_

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 CMN** 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.

## Item to be ordered:

- \_\_\_\_\_ **L0648 Provides anterior and posterior spinal support.**
- \_\_\_\_\_ **L0650 Modular brace, provides anterior, lateral and posterior support,**
- \_\_\_\_\_ **L0457 TLSO - Covers S1 - T4, full spine support (includes shoulder straps)**
- \_\_\_\_\_ **Other:** \_\_\_\_\_

**Please indicate which of the following indications 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"/> S33.5XXA - Lumbar Strains/Sprain    | <input type="checkbox"/> M54.5 - Lumbago                   | <input type="checkbox"/> M62.81 - Muscle Weakness                          |
| <input type="checkbox"/> M51.36 - Lumbar Disc Degeneration   | <input type="checkbox"/> M05.9 Arthritis, Rheumatoid       |  |
| <input type="checkbox"/> M47.817 - Lumbosacral Spondylosis   | <input type="checkbox"/> Q76.2 - Spondylolisthesis         | <input type="checkbox"/> R20.2 Paresthesia                                 |
| <input type="checkbox"/> M19.90 Osteoarthritis, Degenerative | <input type="checkbox"/> M25.60 Joint Stiffness            | <input type="checkbox"/> S33.5 Lumbar Sprain/Strain                        |
| <input type="checkbox"/> M62.50 Disuse Atrophy               | <input type="checkbox"/> M62.81 Muscle Weakness            | <input type="checkbox"/> M51.36 Degeneration of lumbar or lumbosacral disc |
| <input type="checkbox"/> M53.2X9 Spinal Instability          | <input type="checkbox"/> M51.26 - Lumbar Disc Displacement | <input type="checkbox"/> Other: _____                                      |

**Estimated length of need: 3-6 Months During Ambulation or (# of months) \_\_\_\_\_ (99 = lifetime)**

BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription/SWO and I certify that the above prescribed item is medically necessary and reasonable, and is consistent with the current standards of medical practice and treatment of this patient's condition. I will maintain an original, signed copy of this physician order in my medical records and make it available to Medicare, their authorized agents, or other insurer, if required. **\*\*\* Medical justification must be documented in the patient's medical record \*\*\***

**Physicians Signature:** \_\_\_\_\_ **NPI#** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE FAX THIS FORM WITH QUALIFYING CLINICAL NOTES TO 704-821-7777**

Mobility & More | 251 N Trade St. Matthews, NC 28105 | Office 704-821-7777