3939 Royal Drive
Suite 139
Kennesaw, GA 30144

MEDCARE SUPPLY.COM

Tax ID: 81-0690672
National Provide Number: 1063879252

info@medcaresupply.com
Phone: 1-800-528-8606
Fax: 1-800-856-4666

PRESCRIPTION / ORTHOTICS ORDER FORM

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____

City: _____ **State:** _____ **Zip:** _____ **Patient's Phone:** Home: _____Mobile: _____

WRITTEN ORDER

I certify that the equipment listed below is medically necessary as part of the conservation care plan for the patient.

BRACING:

___ LSO ___ TLSO

___ To reduce pain by restricting mobility of the trunk (MUST BE NOTED IN CLINICALS)
___ To facilitate healing following an injury to the spine or related soft tissue (MUST BE NOTED IN CLINICALS)
___ To facilitate healing following a surgical procedure on the spine or related soft tissue (MUST BE NOTED IN CLINICALS)
___ To otherwise support weak spinal muscles and/or a deformed spine (MUST BE NOTED IN CLINICALS)

___ Cervical Collar

___ Wrist (Left / Right / Bilateral)

___ Ankle (Left / Right / Bilateral)

KNEE BRACING:

___ ROM Hinge – Dual Instability
___ Hinged Neoprene
___ Freestyle OA Knee Single Upright (Medial / Lateral)
___ Ligament / Dual Upright OA Knee

ICD-10 (9) CODES:

___ G56.00 (354.0) Carpal Tunnel Syndrome
___ M17.10 (715.16) OA of the Knee
___ M23.50 (717.83) Ligament Tear
___ M47.819 (721.90) Spondylosis
___ M48.06 (724.0) Spinal Stenosis
___ S32.0 (805.4) Compression Fracture
___ M47.819 (722.1) Lumbar Disk Displacement
___ M48.02 (723.0) Spinal Stenosis Cervical
___ M50.30 (722.4) Cervical DDD
___ M54.2 (723.1) Cervicalgia
___ M51.35 (722.51) Thoracolumbar DDD
___ M51.36 (722.52) Lumbar DDD
___ M54.30 (724.3) Sciatica
___ M54.16 (724.4) Lumbar Radiculopathy
___ M62.50 (728.2) Muscle Atrophy
___ M23.40 (717.6) Loose body in Knee
___ M94.20 (733.92) Chondromalacia
___ M15.0 (715.0) Degenerative Joint Disease
___ M54.12 (723.4) Radiculopathy Cervical
___ M62.81 (728.87) Muscle Weakness
___ M79.609 (729.5) Limb Pain
___ Q76.2 (756.12) Spondylolisthesis
___ S86.819a (844.8) Knee Sprain
___ M23.50 (718.86) Knee Instability
___ M22.40 (717.7) Chondromalacia, Patellae
___ M47.812 (721.0) Spondylosis Cervical
___ Other _____

Duration – Patient has had this condition for _____ years _____ months.

I certify this equipment is needed for an indefinite period of time (purchase), to improve the patient's functional mobility.

Physician's Name: _____ NPI Number: _____

Physician's Signature: _____ Date: _____
Signature Required – No Stamps

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