Rx – Prescription & Letter of Medical Necessity

17 Charles St
Binghamton, NY 13905
800-485-9717
607-584-5560 ♦ Fax 607-584-5561

Patient:

_____ _____
First Name **Last Name**

_____ _____ _____
DOB **Social Security #** **Phone #**

DO NOT SUBSTITUTE

- ☐ **Air-Stirrup, Ankle Stabilizer**
- ☐ **Quick-Fit Wrist, WHO**
- ☐ **Quick-Fit Wrist/Thumb, WTO**
- ☐ **Imak Pil-O-Splint, WHFO**
- ☐ **ComfortForm Lumbar Corset**
- ☐ **Reddie Knee Brace, Hinged KO**
- ☐ **Patella Knee Wrap**
- ☐ **Pneumatic Armband, EO**
- ☐ **Quickdraw RAP, LSO**
- ☐ **Sierra Universal Cervical Collar**
- ☐ **Other** _____

Affected Joint:

☐ **Right** ☐ **Left** ☐ **N/A**

Diagnosis:

Primary Diagnosis: _____ ICD-9 Code _____
Secondary Diagnosis: _____ ICD-9 Code _____

Medical Necessity:

- ☐ Weakness or deformity of the joint requiring stabilization
- ☐ Control inversion and eversion of joint
- ☐ Dislocation or distortion of joint
- ☐ Acute sprain or strain
- ☐ Trigger point therapy
- ☐ Inhibit intractable pain
- ☐ Chronic joint pain
- ☐ Brace worn for all activity
- ☐ Brace needed for long term wear
- ☐ Defer Surgery
- ☐ Not candidate for surgery
- ☐ Other (please print) _____

_____

Prognosis:

- ☐ Reduced pain
- ☐ Return to work
- ☐ Increased function
- ☐ Return to activities of daily living
- ☐ Joint stabilization

Physician Signature:

_____ _____
Physician Name **Phone #**

_____ _____
UPIN # / NPI # **FAX #**

I certify that the above-prescribed equipment is medically indicated and in my opinion is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's medical condition.

_____ _____
Physician's Signature **Date**