NPI #: 1932541646

PRESCRIPTION ORDER FORM

Customer Service: (813) 922-3150

FAX TO (813) 922-3152

Corporate Address:
7624 Bald Cypress Place, Tampa, FL 33614

Patient Name ____

Date of Birth ______________ Date of Onset of Symptoms ______________

REQUESTED PRODUCT(S):

- ☐ **E0730** - InTENSity™ 10 & Supplies
- ☐ **L0180/L0160** - Ambulatory Collar
- ☐ **L3807/L3809** - Wrist Brace **(Side: ☐L ☐R)**
- ☐ **L3960** - Shoulder Brace **(Side: ☐L ☐R)**
- ☐ **E0855** - Cervical Traction
- ☐ **L3760** - Elbow Brace **(Side: ☐L ☐R) (Size: ____)**
- ☐ **L1971** - Ankle Brace **(Side: ☐L ☐R)**

STEP 1 - Select Diagnosis Code(s)

(Circle primary code if multiple)

☐ **Primary Code** *(if not an option)*: ____

- ☐ **M25.511** - Pain in the right shoulder
- ☐ **M79.641** - Pain in right hand
- ☐ **M25.521** - Pain in right elbow
- ☐ **M25.512** - Pain in the left shoulder
- ☐ **M79.642** - Pain in left hand
- ☐ **M25.522** - Pain in left elbow
- ☐ **M25.519** - Pain in unspecified shoulder
- ☐ **M25.539** - Pain in unspecified wrist
- ☐ **M25.529** - Pain in unspecified elbow
- ☐ **M79.671** - Pain in right foot
- ☐ **M79.604** - Pain in right leg
- ☐ **M25.571** - Pain in right ankle and joints of right foot
- ☐ **M79.672** - Pain in left foot
- ☐ **M79.605** - Pain in left leg
- ☐ **M25.572** - Pain in left ankle and joints of left foot
- ☐ **M79.673** - Pain in unspecified foot
- ☐ **M79.606** - Pain in unspecified leg
- ☐ **M25.579** - Pain in unspecified ankle and joints of unspecified foot

STEP 2 - Select Medical Necessity

(Select ALL that apply)

- ☐ Retard/diffuse muscle atrophy
- ☐ Retard/diffuse muscle weakness
- ☐ Stimulate muscle contractions
- ☐ Relax muscle spasms
- ☐ Re-educate Muscles
- ☐ Increase range of motion
- ☐ Pain Control (Chronic)
- ☐ Pain Control (Post-Surgical)
- ☐ Reduce edema
- ☐ Other ____

STEP 3 - Select Previous Treatment(s)

(Select ALL that apply)

- ☐ Prior Surgery
- ☐ NSAIDS/ Pain Medications
- ☐ Physical Therapy
- ☐ Injections
- ☐ Other ____

STEP 4 - Specify Length of Need

(Select one)

☐ 12+ months (longterm use) ☐ #______ months (1-11)

STEP 5 - Physician Signature

By my signature, I am prescribing the item listed above. In my judgment, the above-prescribed item is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

Physician Name (Please Print) ______________________________ **NPI#** ______________

***Physician Signature** (NO STAMPS) ______________________________ **Date** ______________

PLEASE FAX COMPLETED FORM AND MEDICAL NOTES TO (813) 922-3152

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