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

☐ **L1832/L1833** - Knee Brace **(Side: ☐L ☐R) (Thigh: ____)**

STEP 1 - Select Diagnosis Code(s)

(Circle primary code if multiple)

Primary Code *(if not an option)*: ______________________

☐ **M06.861** - Other specified rheumatoid arthritis, right knee

☐ **M06.862** - Other specified rheumatoid arthritis, left knee

☐ **M17.0** - Bilateral primary osteoarthritis of knee

☐ **M17.11** - Unilateral primary osteoarthritis, right knee

☐ **M17.12** - Unilateral primary osteoarthritis, left knee

☐ **M23.51** - Chronic instability of knee, right knee

☐ **M23.52** - Chronic instability of knee, left knee

☐ **G35** - Multiple sclerosis

☐ **M23.611** - Other spontaneous disruption of anterior cruciate ligament of right knee

☐ **M23.612** - Other spontaneous disruption of anterior cruciate ligament of left knee

☐ **M23.631** - Other spontaneous disruption of medial collateral ligament of right knee

☐ **M23.632** - Other spontaneous disruption of medial collateral ligament of left knee

☐ **M23.206** - Derangement of unspecified meniscus due to old tear or injury, right knee

☐ **M23.207** - Derangement of unspecified meniscus due to old tear or injury, left knee

☐ **S83.203A** - Other tear of unspecified meniscus, current injury, right knee

☐ **S83.204S** - Other tear of unspecified meniscus, current injury, left knee

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

ST2017-80 REV04 All Rights Reserved. ©2018 STYMCO Medical, LLC