DME Living Well

CORFLEX Braces

Prescription Form

PATIENT NAME ____________________

DATE OF BIRTH ____________________

PATIENT PHONE ____________________

ICD-10 CODE ____________________

DIAGNOSIS ____________________

PHYSICIAN NAME ____________________

PHYSICIAN NPI# ____________________

FACILITY NAME ____________________

ADDRESS ____________________

____

CITY ____________________

STATE ____________ ZIP ____________

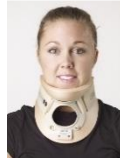
OFFICE PHONE ____________________

OFFICE FAX ____________________

Prescribed Product

Ultra Cervical Collar
L0120
O

Rigid Cervical Collar w/Trachea
L0172
O



Ambu Perfit Collar
L0140
O

Wrist/Hand Orthosis
L3984
O

Ultra Clavicle Strap
L3650
O

Universal Abd. Binder
O 9”
O 12”

Universal Shoulder Immobilizer
L3650
O

Elastic Shoulder Immobilizer
O

Required Length:

ADDITIONAL COMMENTS

It is my expert opinion that the product indicated for the above-named patient is medically reasonable and necessary to facilitate management of this patient's diagnosis. Please dispense as written.

PHYSICIAN/PROVIDER SIGNATURE ____________________ DATE ____________
(WITH CREDENTIALS)

Dispense as Written. No Substitutions.