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

Extended Length Boxer Splint
L3807 or 3809
O

Colles Splint
L3807 or L3809
O

Ulnar Splint
L3982
O

Thumbster Soft
L3807 or L3809
O

Low Profile Thumbster
L3923 or L3924
O

Ultra Fit Wrist Splint
L3908
O

Cock-Up Splint
L3908
O

Signature Wrist Splint w/Abd.Thumb
L3807 or L3809
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.