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 ______________________________

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CITY ______________________________

STATE ______________ ZIP ______________

OFFICE PHONE ______________________________

OFFICE FAX ______________________________

Prescribed Product

Marathon Ankle Stirrup w/Air-Gel
L4350
O

Universal Lace Wrist w/Abd Thumb
L3807 or L3809
O

Marathon Active Lace Up Ankle
L1902
O

Ultra Stretch PF Splint
L4396 or L4397
O

Levamed Ankle Support
O

6” Knee-o-Trakker
L1810 or L1812
O

Knee Wrap Univ Hinged
L1810 or L1812
O

Tri Panel Knee Immobilizer
L1830
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.