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

Med Surg Post Op Shoe
L3260
O

Post-Op Shoe Velcro
L3260
O

16" Ant Closure w/ ROM Hinge
L1832 or L1833
O

Pat. Stabilizer Cor-Trak Buttress
O

Tri Shell Pneumatic Walker
L4360 or L4361
O Tall
O Short

Pneumatic Walker
L4360 or L4361
O Tall
O Short

Ant. Closure Knee Wrap w/Hinge
L1820
O

Ant. Closure w/ROM Hinge
L1832 or L1833
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.