The DIABETIC Shoppe
1068 Factory Drive ~ Charleston, MS 38921
Toll-Free Phone: 1-888-571-3533 ~ Toll-Free Fax: 1-800-520-8117

Wrist Hand Finger Orthosis Prescription Form

Step 1

Patient ID#:_____ Effective Date:_____

Patient Name: Mr/Ms_____ SS#:_____

Address:_____ City:_____,_____ Zip:_____

Phone:_____ Birthday:_____

Primary:_____ Secondary:_____

Policy #:_____ Policy #:_____

Insulin Treated? Yes _ No _ **ICD-10 Diagnosis Code:.**

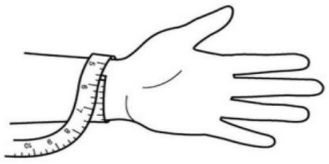
- ❑ Rheumatoid Arthritis-Unspecified…M06.9
- ❑ Osteoarthrosis-Localized In Hand…M18.9
- ❑ Osteoarthrosis-Unspecified…M19.90
- ❑ Other (Please specify) _____
- ❑ **Carpal Tunnel Syndrome E56.00**

Patient Sizing, Wrist Specifications and Item Description

Step 2

Please choose the size based on wrist circumference at Ulnar Prominence

Size	Wrist Circumference
❑ Small	6" to 6.5" or 12.7cm to 16.5cm
❑ Medium	6.25" to 7.75" or 15.9cm to 19.7cm
❑ Large	7.5" to 9"or 19cm to 22.9cm



Please specify wrist for treatment:

❑ - Right ❑ - Left ❑ - Both

Item Description & HCPCS Code:
Wrist hand finger orthosis – L3807
Wrist hand finger orthosis, without joint(s), prefabricated, includes fitting and adjustment

Item Description & HCPCS Code: **Wrist hand finger orthosis – L3809** Wrist hand finger orthosis, without joint(s), prefabricated, includes fitting and adjustment

REASON FOR MEDICAL NECESSITY AND LENGTH OF NEED:

MEDICARE REQUIRES A REASON(S) FOR A WRIST HAND FINGER ORTHOSIS. I confirmed that I have seen this patient within the last six (6) months to evaluate their above mentioned diagnosis, have reflected need in their most recent medical chart, have identified the reason(s) for using this orthosis below:

- ❑ OSTEOARTHROSIS
- ❑ CARPAL TUNNEL SYNDROME
- ❑ LIGAMENT INSTABILITY
- ❑ OTHER:

LENTH OF NEED IS **99 MONTHS** (unless specified): _____ months

Step 3

Print Physician's Name:_____ Ph #:_____

Physician Signature:_____ Date:_____

NPI:_____ DEA#_____ City:_____, ST:_____

By signing above, I agree to obtain the original, signed copy of this document in my medical records. My medical records and recent charts substantiate I am treating this patient under a comprehensive care plant for the above mentioned diagnosis and the patient is able to use this item herein ordered to manage his/her condition. This order accurately reflects the patient's documented diagnosis, condition, prescribed treatment and testing regimens.

Accredited by
JCAHO