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

Spinal 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:.

❑ Spinal Stenosis…M48.0
❑ Herniated Disk (Lumbar)…M51.27
❑ Degenerative Disk Disease…M51.34
❑ Spondylolisthesis Q76.2
❑ Other (Please specify) _____

Patient Sizing and Item Description

Please choose the size based on measurement around largest part of patient's abdomen

Step 2

Size	Waist Circumference
❑ X-Small	24" to 28"
❑ Small	29" to 33"
❑ Medium	34" to 39"
❑ Large	40" to 44"
❑ X-Large	45" to 49"
❑ 2X-Large	50" to 54"
❑ 3X-Large	55" to 59"
❑ 4X-Large	60" to 64"

ITEM DESCRIPTION & HCPCS CODE: *Mark Type of Brace*	
___ L0631	___L0627
Lumbar Sacral Orthosis, Sagittal-Coronal Control, with Rigid Anterior & Posterior panels, Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra.	Lumbar Sacral Orthosis, Sagittal-Coronal Control, with Rigid Anterior & Posterior panels, Posterior Extends from Sacrococcygeal Junction to Lumbar 5.

REASON FOR MEDICAL NECESSITY AND LENGTH OF NEED:

MEDICARE REQUIRES A REASON(S) FOR A SPINAL 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:

❑ Reduce pain by restricting mobility of trunk
❑ Facilitate healing from spinal or soft tissue injury or surgical procedure
❑ Support weak spinal muscles and/or a deformed spine
❑ 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