NextGen
Medical Supplies, Inc.

Prescription Authorization
Signature Required
ID:

RX FOR ANKLE BRACE
PLEASE FAX TO: (888) 613-5719

PRESCRIPTION DATE:

A. PATIENT INFORMATION	B. PHYSICIAN INFORMATION
Name: **Address:** **Phone#:** **DOB:**	**Name:** **Address:** **NPI:** **PHONE#:** **FAX#:**

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Step 1

AFFECTED FOOT*

☐ **LEFT** ☐ **RIGHT** ☐ **BILATERAL**

EQUIPMENT REQUESTED BY PATIENT (Please Initial any Changes)

☐ **L1902 Ankle Foot Orthosis, Ankle Gauntlet, Prefabricated, Off-The-Shelf**

Length of Need (Lifetime unless otherwise specified): _____

DIAGNOSIS

☐ **M25.579 Pain in Unspecified Ankle and Joints of Unspecified Foot**

☐ **Additional Diagnosis** _____

MEDICAL NECESSITY

☐ Weakness or deformity of the ankle that requires stabilization to benefit functionality

Step 2

SIGNATURE & DATE - By signing below, I confirm the medical supplies herein are medically necessary and that this prescription is valid for NextGen Medical Supplies Inc. I have had a face-to-face encounter with this patient within the last 6 months and have documented the condition related to this order in their medical record. I will furnish substantiating medical records upon request.

Physician Signature: _____ **Date:** _____/_____/_____

Printed name and NPI required of signing physician if different from provider printed above

Printed Name: _____ **NPI:** _____

Start Date: _____

IMPORTANT: RETURN WITH A COPY OF THE PATIENT'S MEDICAL RECORD ASSOCIATED WITH THE REQUESTED PRODUCT

PLEASE FAX TO: (888) 613-5719

Customer Service: (888) 557-7085

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