NextGen
Medical Supplies, Inc.

Prescription Authorization
Signature Required

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

ID:

PRESCRIPTION DATE:

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

Rx

EQUIPMENT REQUESTED BY PATIENT

- ☐ L0648 Lumbar-Sacral Orthosis* – Sagittal control with rigid anterior and posterior panel; posterior extends from Sacrococcygeal Junction to T-9 Vertebra; produces intracavitary pressure to reduce load on the invertebral discs; includes straps, closures, may include padding, shoulder straps, pendulous abdomen design; prefabricated, off-the-shelf.
- ☐ L0642 Lumbar-Sacral Orthosis* – Sagittal control with rigid anterior and posterior panel; posterior extends from L-1 to below L-5 Vertebra; produces intracavitary pressure to reduce load on the invertebral discs; includes straps, closures, may include padding, shoulder straps, pendulous abdomen design; prefabricated, off-the-shelf.

Length of Need (Lifetime unless otherwise specified): _____*May be supplied depending on insurance

DIAGNOSIS

- ☐ **M54.5 Chronic Low Back Pain (Lumbago)**
- ☐ **M53.9 Back Disorder, Unspecified; Dorsopathy**
- ☐ **Additional Diagnosis** _____

MEDICAL NECESSITY

- ☐ To support weak spinal muscles and/or a deformed spine
- ☐ To facilitate healing following a surgical procedure on the spine or related soft tissue
- ☐ To facilitate following an injury to the spine or related soft tissue
- ☐ To reduce pain by restricting mobility of trunk

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

Customer Service: (888) 557-7085

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