NextGen
Medical Supplies, Inc.

Prescription Authorization
Signature Required

RX FOR WRIST 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:**

AFFECTED HAND*

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

EQUIPMENT REQUESTED BY PATIENT

☐ **L3916 Wrist Hand Orthosis Nontorsion Joint(s) Prefabricated, Off-the-shelf**

☐ **L3809 Wrist Hand Finger Orthosis Without Joint(s) Prefabricated, Off-the-shelf**

Length of Need (Lifetime unless otherwise specified): _____

DIAGNOSIS

☐ **G56.00 Carpal tunnel syndrome, unspecified upper limb**

☐ **Additional Diagnosis** _____

☐ **Additional Diagnosis** _____

MEDICAL NECESSITY

I attest that my patient requires the device listed above for one or more of the following medical necessity reasons:

☐ **Weakness or deformity of the hand and/or wrist**

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

NextGen Medical Supplies, Inc.
601 N. Congress Ave. Suite 439B.
Delray Beach. FL 33445