



MEDICAL SUPPLY

Voice: 1-800-657-4090

Fax: 1-866-626-7881

RX: Back Support (Lumbar-Sacral Orthosis - sagittal coronal control – L0637)

Patient's Name: _____ HIC#: _____
Address: _____ DOB: _____

Insurance Name: _____
Insurance Phone: _____
Phone: _____

Patient's Waist Size: _____ inches

Physician Name: _____ NPI: _____
Address: _____

Physician Phone: _____ Fax: _____

One or more of the following conditions must be met, **please check all that apply:**

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

In order the patient to qualify under Medicare guidelines for the LSO Back Brace, an Rx is required from the Doctor indicating that there is a Medical Necessity for the patient to receive the LSO Back Brace. **Some of the diagnoses include, please check all that apply:**

- 724.2 Lumbago
- 724.02 Spinal Stenosis
- 728.88 Muscle Weakness
- 756.13 Spondylolisthesis
- 722.11 Lumbar Disc Displacement
- 721.42 Lumbosacral Spondylosis
- 847.3 Lumbar Strains/Sprain
- 724.1 Pain in Thoracic Spine
- 722.52 Lumbar/Lumbosacral Intervertebral Disc Degeneration

Estimated length of need (# of months) _____ (99 = lifetime)

Physician's Signature: _____ Date signed: ____/____/____