CERTIFICATE OF MEDICAL NECESSITY

ATTENTION PROVIDER: A copy of this completed document should be retained in the patient's medical record.

TO BE COMPLETED BY SUPPLIER

Certification Type/Date: INITIAL __/__/__ REVISED __/__/__ RECERTIFICATION__/__/__

PATIENT NAME, ADDRESS, PHONE, INSURANCE NAME & ID#	**SUPPLIER NAME, ADDRESS, PHONE/FAX, NPI# & PTAN**
PT DOB__/__/__ Sex____ (M/F) HT.____ (in.) WT.____ (lbs.)	**PHYSICIAN NAME, ADDRESS, PHONE/FAX & NPI#**
PLACE OF SERVICE_____ **NAME & ADDRESS OF FACILITY (if applicable)**	

HCPCS CODE(S): L0631 _____ _____ _____ ITEM NAME: BabyBrace®/ Lumbar-Sacral Orthosis, Custom fitted

DETAILED NARRATIVE DESCRIPTION OF ITEM PRESCRIBED/ORDERED BY PHYSICIAN: (attach medical records for support)

Full Description: Lumbar-sacral orthosis, sagittal control, with rigid anterior & posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded assembled, or otherwise customized to fit a specific patient by an individual with expertise.

TO BE COMPLETED BY PHYSICIAN

ESTABLISHED LENGTH OF NEED (# OF MONTHS):_____ 1-99 (99=LIFETIME)

ICD-10 DIAGNOSIS CODE(S): _____ _____ _____ _____ _____

(Primary ICD-10 DX) (Additional DX code(s) that further describe the medical need for the item)

Physician Attestation and Signature/Date

I certify that I am the treating physician identified on this form and that the patient named above is a patient in my office.
Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact on this form may be subject to civil or criminal liability.
I have prescribed the above listed item(s) as an essential part of my treatment plan for this patient. This item is not being prescribed as a comfort or convenience item but is reasonable and necessary for the proper treatment of my patient's condition. This item is being prescribed to:

◯Stabilize the injured or diseased area.

◯To reduce and/or alleviate pain by restricting mobility of the trunk.

◯To support weak spinal muscles and/or a deformed spine.

◯To facilitate healing following a surgical procedure on the spine or related soft tissue.

◯Other (please specify): _____

PHYSICIAN SIGNATURE:_____ DATE:_____

FAX to: 813.354.4756 or EMAIL to: info@vmhbracing.com INCLUDE: Prescription Order Form and Supporting Medical Records.