



## PRESCRIPTION/ORDER FORM

Phone: 813.515.5066 Toll Free Phone: 844.402.8489 Fax: 813.354.4756 Email: info@vmhbracing.com

### PATIENT INFORMATION

Complete patient information below or attach patient demographic sheet that includes insurance information.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Order Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
(Home/Cell/Work)

Primary Insurance & ID#: \_\_\_\_\_ Secondary Insurance & ID#: \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Child Date of Injury: \_\_\_\_\_ (required for all INJURY CLAIMS)

Waist Circumference (Inches): \_\_\_\_\_ Current Gestational Age: \_\_\_\_\_ Weeks: \_\_\_\_\_ Days: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### PRESCRIBER INFORMATION

Physician/Prescriber Name: \_\_\_\_\_ NPI#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**\*\*Please include chart notes (with supporting indication of medical necessity), demographics, and Certificate of Medical Necessity (attached) Fax to 813.354.4756 or Email to: info@vmhbracing.com**

### ORDER INFORMATION

Item prescribed: Lumbar Sacral Orthosis, Custom fitted.

HCPCS Code:  L0631 BabyBrace Quantity Dispensed: 1  Brace Extender

Indicate the patient's primary ICD-10 Diagnosis Code which requires the use of an LSO: \_\_\_\_\_

#### PRIMARY DIAGNOSIS

##### Lumbago with Sciatica

- M54.40 unspecified side  
 M54.41 right side  
 M54.42 left side

##### Sciatica

- M54.30 unspecified side  
 M54.31 right side  
 M54.32 left side

##### Sagittal Plane Imbalance

- M43.8x7

##### Coronal Plane Imbalance

- M43.8x7

##### Radiculopathy

- M54.10 unspecified side  
 M54.14 thoracic region  
 M54.15 thoracolumbar region  
 M54.16 lumbar region

##### Low Back Pain

- M54.50 low back pain, unspecified

##### Pain in Thoracic Spine

- M54.6

##### Acute Post-op Pain (C/S)

- G89.18

##### Deforming Spinal Diseases

- M40.45 postural acquired lordosis, thoracolumbar region  
 M40.46 postural acquired lordosis, lumbar region  
 M40.47 postural acquired lordosis, lumbosacral region  
 M40.55 lordosis, unspecified, thoracolumbar region  
 M40.56 lordosis unspecified, lumbar region  
 M40.57 lordosis unspecified, lumbosacral region

##### Traumatic Symphysis Pubis Diastasis

- O71.6

##### Meralgia Paresthetica

- M43.8x7 unspecified, lower limb

#### SECONDARY DIAGNOSIS

##### ROUND LIGAMENT PAIN AFFECTING ANTE PARTUM

- O26.891 first trimester  
 O26.892 second trimester  
 O26.893 third trimester  
 O26.899 unspecified trimester

##### Other DX code(s):

MEDICAL NECESSITY DISCLAIMER: By my signature below, I am prescribing the brace listed above. The items listed above are requested based on the patient's diagnosis. This item will or is reasonably expected to assist the patient in achieving and maintaining maximum functional capacity in performing daily activities.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature Stamps NOT Accepted)