Durable Medical Equipment Prescription/Order

Phone: 813-515-5066 Toll Free Phone: 844-402-8489 Fax: 813-354-4756 Email: info@babybrace.com

Patient Information	Physician Name, Address, Phone/Fax & NPI#	Supplier
Name: _____ DOB: _____ Address: _____ Phone: _____ Insurance: _____ EDD: _____ Circumference:		

Lumbar Sacral Orthosis	HCPCS Code: L0631/L0648 (Baby Boost AB1001)

DIAGNOSES

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

Traumatic Symphysis Pubis Diastasis
- ☐ O71.6

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

Meralgia Paresthetica
- ☐ M43.8x7 unspecified, lower limb

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

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):
- ☐ E66.9 obesity unspecified
- ☐ O99.210 obesity complicating pregnancy
- ☐ _____
- ☐ _____

Certificate of Medical Necessity

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. * L0648 for off the shelf distribution.

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

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 pain by restricting mobility of the trunk
- ◯ Assist in returning the patient to normal activities of daily living
- ◯ Decrease pain
- ◯ To facilitate healing following an injury to the spine or related soft tissue.
- ◯ To facilitate healing following a surgical procedure on the spine or related soft tissue
- ◯ To prevent delay of surgery
- ◯ To support weak spinal muscles and/or a deformed spine

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)