

Detailed Written Order



Instructions

1. Complete all fields on this Detailed Written Order.
2. Use the Noridian November 2017 Physician Resource Letter to confirm coverage criteria and medical necessity documentation requirements are met.
3. Fax both this order and the patient's most recent medical records that demonstrate coverage criteria are met to a DME supplier that provides the Dr. Joint Care, Inc. system.

Patient Information

Patient Name: _____ Date of Birth: _____
Phone: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Insurance: _____ Primary Insurance Member ID: _____
Secondary Insurance: _____ Secondary Insurance Member ID: _____
Notes: _____

Physician Information

Physician Name: _____ Phone: _____
NPI: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Order Detail

Order Date: _____

Back Brace (LSO)

- Low Back Pain M54.5
- Spinal Stenosis, Lumbar Region M48.061
- General Muscle Weakness M62.81
- Intervertebral Disc Displacement M51.26
- Lumbar Spondylosis M47.896
- Lumbar Intervertebral Disc Degeneration M51.36

Ankle Brace w/ Foot Healer Stabilizer L3170

- Contracture, (Ankle/Foot) M24.571 and/or M24.572
- Ligament Sprain S93.491A and/or S93.492A
- Ligament Sprain S93.491D and/or S93.492D
- Sprain S93.601A and/or S93.602A
- Sprain S93.601D and/or S93.602D

Cervical Brace

- Cervicalgia M54.2
- Radiculopathy M54.02
- Spinal Stenosis, Cervical Region M48.02
- Osteoarthritis M19.90

Elbow Brace

- Effusion M25.421 and/or M25.422
- Recurrent Dislocation M24.421 and/or M24.422

Medical Necessity & Length of Need

- Support weak spinal muscles and/or deformed spine
- Facilitate healing following injury to the spine or related soft tissue
- Reduce pain by restricting mobility of the trunk
- Facilitate healing following a surgical procedure on the spine or related soft tissue

Knee Brace w/Suspension Sleeve L2397

- Chondromalacia of Patella M22.41 and/or M22.42
- Chronic Instability of Knee M23.51 and/or M23.52
- Rheumatoid Arthritis w/ Rheumatoid Factor M05.861 and/or M05.862
- Osteoarthritis - Knee (Unspecified) M17.9
- Multiple Sclerosis G35

Wrist Brace

- Carpal Tunnel Syndrome G56.01 and/or G56.02
- Pain in Wrist M25.531 and/or M25.532
- Unspecified Sprain of Wrist S63.501A and/or S63.502A
- Sprain of Carpal Joint of Wrist S63.511A and/or S63.512A
- Unspecified Sprain of Wrist S63.501D and/or S63.502D

Shoulder Brace

- Adhesive Capsulitis M75.01 and/or M75.02
- Impingement Syndrome M75.41 and/or M75.42
- Primary Osteoarthritis M19.011 and/or M19.012
- Pain in Shoulder M25.511 and/or M25.512

Other

- Description _____
- Description _____

- Facilitate healing post injury or surgery
- Weakness or deformity of the foot and ankle
- Reduce pain by restricting joint movement

_____ Length of need (Length of need is LIFETIME [99 months] unless otherwise noted)

I certify that I am the physician identified in the "Physician Information" section above and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician Signature: _____ Date: _____

It is ultimately the responsibility of the healthcare professional/persons associated with the patient's care to determine and document the appropriate diagnosis(es) and code(s) for the patient's condition. Dr. Joint Care, Inc. does not guarantee that the use of any information provided in this form will result in coverage or payment by any third-party payer. Each healthcare provider is ultimately responsible for verifying codes, coverage, and payment policies used to ensure that they are accurate for the services and items provided.



PLEASE SEND FAX TO (866)984-2565