CMN for Lumbar-Sacral Orthosis Back Support

Patient Name: _____ Patient DOB: _____

Medicare # _____ Patient Phone: _____

Treating Physician: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Physician Phone: _____ Physician Fax: _____

INSTRUCTIONS: The above named patient has requested that you fill out this order form. Please complete *entire* form and fax to the number below. Per Medicare guidelines we are required to obtain **progress notes** along with this **signed RX** and **qualifying diagnosis code(s)** for product sought by your patient. Please make sure the supporting documentation is faxed to validate **medical necessity** in order to facilitate your patients' request. Unfortunately, without these necessary documents we will not be able to supply the product requested by your patient.

Item(s) to be ordered:

A lumbar-sacral orthosis _____ L0627 _____L0637 or _____
L0637 is covered when it is ordered for one of the following indications:

Please indicate which of the following conditions apply to the patient. Check all that apply.

- ☐ To reduce pain by restricting mobility of the truck: 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 tissue: or
- ☐ To otherwise support weak spinal muscles and/or a deformed spine.

Please choose ICD-10

☐ M12.90 Arthropathy	☐ M19.90 Osteoarthritis, Degenerative	☐ M05.9 Arthritis, Rheumatoid
☐ M25.60 Joint Stiffness	☐ S33.5XXA Lumbar Sprain/Strain	☐ M54.5 Chronic Low Back Pain
☐ M62.50 Disuse Atrophy	☐ M62.81 Muscle Weakness	☐ _____Other **ICD-10**

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

This patient is being treated under a comprehensive plan of care for arthritis/pain. I, the undersigned certify that the above prescribed is medically necessary for the patients' overall wellbeing. In my opinion, the following orthotic/arthritic relief products are both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be made available upon request.

Physicians Signature: _____ NPI# _____ Date: _____

****PLEASE FAX THIS ORDER TO 310.330-7635 ****

Confidence First Medical Supplies
316 E Manchester Blvd Inglewood, CA 90301
P:(310) 330-7636 F:(310) 330-7635

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