800.838.3560
866.598.3366

Eden MEDICAL SUPPLY

BACK BRACE DETAILED WRITTEN ORDER

Patient Information

Name:
Date of Birth:
Phone Number:
Address:

Insurance ID:
Insurance Name:
Gender:

Physician Information

Name:
NPI:
Address:

Phone:
Fax:

Email:

① **Equipment to Prescribe** (please select one)

- ☐ **L0650 – LUMBAR-SACRAL ORTHOSIS**, saggital coronal control with rigid anterior and posterior panels, lateral strength provided by rigid lateral frame/panels, prefabricated, off-the-shelf

- ☐ **L0648 – LUMBAR-SACRAL ORTHOSIS,** saggital control with rigid anterior and posterior panels, prefabricated, off-the-shelf

Length of Need: Lifetime – unless otherwise specified here: _____

Statement of Medical Necessity

② **Diagnosis**

Diagnosis Code(s): _____

③ **A back brace is being ordered for one of the following reasons:**

- ☐ To reduce pain by restricting mobility of the trunk
- ☐ To facilitate healing following an injury to the spine or related soft tissues
- ☐ To facilitate healing following a surgical procedure on the spine or related soft tissue
- ☐ To otherwise support weak spinal muscles and/or a deformed spine

④ **Please send medical records to support medical necessity of the back brace.**

I certify that I am the physician identified in the above section and I certify that information contained in this document reflects the patient's condition and is accurate to the best of my knowledge.

⑤ **Date**: _____

⑥ **Physician Signature**: _____