800.838.3560
866.598.3366

Eden MEDICAL SUPPLY

WRIST 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:

Equipment to Prescribe

- **L3916 – WRIST HAND ORTHOSIS**, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf.

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

Statement of Medical Necessity (please complete 1-5)

① **Diagnosis**

Diagnosis Code(s): _____

② **Which side requires a wrist brace?**

- ☐ BOTH
- ☐ RIGHT
- ☐ LEFT

③ **Please send medical records to support medical necessity of the wrist 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.

④ **Date**: _____

⑤ **Physician Signature**: _____