800.838.3560
866.292.6645

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

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

Size: _____

Statement of Medical Necessity (Items 2-6 REQUIRED**)**

② Diagnosis

☐ M54.9 ☐ M54.50 ☐ M15.8
☐ M15.0 ☐ G89.29 ☐ **Other:** _____

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**: _____