800.838.3560
866.292.6645

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:

① **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.

Statement of Medical Necessity (Items 2-6 REQUIRED)

② **Diagnosis**

☐ M25.539 ☐ M25.531 ☐ M25.532
☐ G56.02 ☐ G56.03 ☐ Other: _____

③ **Which side requires a wrist brace?**

☐ Both ☐ Left ☐ Right

④ **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.

⑤ **Date**: _____

⑥ **Physician Signature**: _____