# PHYSICIAN'S ORDER
## BACK SUPPORTS (L0627 & L0631)

EFFECTIVE DATE: ____________________

**PATIENT INFORMATION**

NAME (LAST, FIRST):______________________________ PHONE:______________

ADDRESS: ______________________________ CITY ____________________________ STATE ____ ZIP__________

☐ MALE ☐ FEMALE HT. 0 In WT. 0 lbs DATE OF BIRTH ________________ SS#

**DIAGNOSIS**

Length of Need ___

99=Lifetime
Unless otherwise specified

Patient has had condition for:

_____ YRS ____ MTHS

___ 724.2 Low Back Pain
___ 724.6 Lumbar Instability
___ 724.8 Lumbar Facet Syndrome
___ 724.4 Lumbar Radiculopathy
___ 738.4 Spondulolisthesis-Degenerative
___ 722.52 Degenerative Disc Disease
___ OTHER: ____________________________________________

___ 724.02 Spinal Stenosis
___ 724.3 Sciatica
___ 756.11 Spondylosis-Lumbar
___ 729.9 Radiculopathy
___ 756.12 Spondylothesis
___ 722.10 Herniated Disk (Lumbar)

**BACK SUPPORT PRODUCTS & THERAPY INFORMATION**

Please ✓ (check) any conditions that may apply:

___ To otherwise support weak spinal muscles and/or a de formed spine

___ To aid in healing after a surgical procedure on the spine, back or related soft tissue

___ To reduce pain by restricting mo-bility of the trunk

___ To aid in healing after an injury to the spine, back or related soft Tissue

___ Other (please specify)

________________________

Size Ordered: (measured at patients navel)

| Small | Medium | Large | X-Large | 2X-LG | 3X-LG | 4X-LG | 5X-LG |
|---|---|---|---|---|---|---|---|
| (24-28) | (29-33) | (34-39) | (40-44) | (45-49) | (50-55) | (56-59) | (60-64) |

Back Brace Choice Ordered:

____ L0627 Lumbar Orthosis (prefabricated) for posterior support Extending from L1 to below L5 vertebrae (EX: V-LOC LSO)

____ L0631 Lumbar Sacral Orthosis (prefabricated) for posterior support extending from sacrococygeal junction to T9 Vertebrae (EX: CINCH-LOC, X-BACK LSO)

**MUST BE COMPLETED** Previous and/or Existing Medications and/or Therapies have been:

**PHYSICIAN INFORMATION**

NAME (LAST, FIRST):______________________________ PHONE:____________

ADDRESS: ______________________________ CITY__________________________ STATE____ ZIP__________

BY SIGNING BELOW, I AM STATING THAT: I am or was this patient's treating physician during the order period. This order accurately reflects the patient's condition, this prescription is substantiated by medical records. I have seen this patient within the last 6 (six) months. The patient or their caregiver is adequately trained to be able to operate the prescribed equipment. **I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.**

X Physician's Signature:________________________________ Date________ NPI #____________________

SIGNATURE STAMPS NOT ACCEPTED

**PLEASE REMIT BY FAX: (407)849-6458**