

Pro Med Ortho
300 S. Santa Fe Trail
Duncanville, TX 75116

**PHYSICIAN DETAIL WRITTEN ORDER (RX)
AND LETTER OF MEDICAL NECESSITY**

Fax 214-242-8079

PHONE 972-773-9308
Email: intake@promedortho.com

Patient Information

Insurance Information

Name:	Ins. Company:	
Address:	Ins. Phone:	
	Policy ID#:	
Phone:	Group #:	
SS #:	Adj. Name:	PH:
Date Of Birth:	CL #:	DOI:
Prescribing Physician:	ICD10/Diagnosis (REQUIRED):	
Physician Phone #:	Fax #:	NPI #:
Rx: Doctor, please indicate all services you would like Pro Med Inc. to provide to your patient: Please include any special instructions necessary to ensure accurate and specific treatment.		

AMBULATORY ☐ Single Point Cane/4 Point ☐ Crutches ☐ Wheelchair ☐ Light Weight ☐ Ultra Light Weight ☐ Custom ☐ Walker/Rollator Walker/Knee Walker ☐ Raised Toilet Seat ☐ Bed Side Commode	CERVICAL AND LUMBAR ☐ Cervical Collar-Soft/Cervical Collar Semi Rigid-Aspen Therapy Collar ☐ Lumbar Back Brace (LSO) ☐ L0642 / L0627 SIZED ☐ TLSO ☐ L0642 / L0627 ADJUSTABLE ☐ Lumbar Pillow/Orthopedic Cervical Pillow ☐ L0648 / L0631 ☐ Cervical Traction ☐ Lumbar Traction ☐ L0650 / L0637
EXTREMITIES ☐ Hinged Elbow Brace ☐ Wrist Cock Up ☐ Thumb Spica ☐ Breg Shortrunner w/Hinges ☐ Functional ACL Brace ☐ OA Knee Brace ☐ L1845 Custom OA ☐ L1846 ☐ Soft OA Brace Undersleeve ☐ L2397 ☐ Knee Immobilizer ☐ Pneumatic Walking Boot ☐ Fracture Boot ☐ Ankle Brace ☐ Breg Ultra Ankle CTS ☐ Ankle Stir-Up ☐ Shoulder Abduction Sling ☐ Shoulder Immobilizer ☐ Plantar Fasciitis Night Splint ☐ AFO-Standard-Dynamic ☐ Orthopedic Shoes ☐ Orthotics	STIM/EMS ☐ NMES/EMS/TENS Unit (Serial #) _____ ☐ STIM Garment ☐ Conductive Spray 8 OZ 12OZ ☐ Batteries 4 6 8 10 ☐ Electrodes 4PKS PER MTH 1MTH 3MTHS 6MTHS 12MTHS 99MTHS Pain Management/Muscle Skeletal Healing ☐ sam* ☐ Lantz Static/Dynamic Brace ☐ sam* Patches: 2 Months ☐ Brace Type _____ ☐ sam* Patches: 1 Year ☐ Length of need _____ Miscellaneous/Post Op ☐ Hot/Cold Therapy System ☐ DVT Compression System Take Home ☐ Bone Growth Stim ☐ Spinal ☐ Long Bone ☐ Post Op T-Scope Knee Brace Post Op T-Scope Elbow Brace ☐ CPM ☐ Knee ☐ Hand ☐ Lymphedema Compression Unit ☐ Lymphedema Garment ☐ Hip Abd. Brace/Philippon Hip ☐ Abdominal Binder
Home Therapy ☐ Moist/Dry Heat Pad ☐ Bed Wedge ☐ Hand Therapy ☐ Shoulder Therapy Kit ☐ Paraffin Bath ☐ Active Cold Therapy Systems ☐ Paraffin Wax ☐ Ergonomic Chair ☐ Inversion Table	PLACE LABEL HERE ☐ MISC _____ Item Purchase/Rental Serial/Item #

Physician Signature: _____ Date: _____

I have prescribed the above durable medical equipment for treatment of the referenced patient. It is both reasonable and medically necessary effectuate a maximum and expedient recovery. CHECK ALL THAT APPLY. It is prescribed to

- | | |
|---|--|
| ☐ Reduce Pain | ☐ Increase Range of Motion (ROM) |
| ☐ Reduce Muscle Spasm | ☐ Post-Operative/Surgical Procedure |
| ☐ Post- Operative/Post Procedural Pain Control and Edema | ☐ Length of need _____ |
| ☐ Reduce Reliance on Narcotics/Analgesics | ☐ Other (specify below): _____ |
| ☐ Reduce Edema/Swelling | |

To be signed and completed by patient upon receipt of product(s):

Dear Patient: **PLEASE READ THIS STATEMENT AND SIGN BELOW**

Pro Med Inc. is not financially affiliated with the medical group or physician. Your physician must prescribe all services and/or products provided by Pro Med Inc. I hereby authorize Pro Med Inc. to furnish this service/product and to provide my insurance company with any information requested for payment. I also instruct my insurance company to pay Pro Med Inc. directly for these service/products. I understand that all costs for service/products not paid for by my insurance company for any reason will become my personal financial responsibility. Assignment of benefits does not guarantee that my insurance company will pay for these service/products. I have received the above referenced product(s)/services from Pro Med Inc., and have been instructed in the care and use of the product. I understand that all medical devices are not returnable for any reason other than material defect. MEDICARE AND OTHER INSURANCE COMPANIES will only pay for services/products that they determine to be reasonable and necessary under section 1862(a)(1) of the Medicare regulations. It Medicare or other insurance company determines that the product/service, although otherwise a covered product/service, is not reasonable or necessary under Medicare or other insurance company standards. Medicare or other insurance company may deny payment for these service/products. Pro Med Inc. cannot be certain that Medicare or other insurance company will view your doctor's request for the above listed product/service to be reasonable or necessary or that your doctor's supporting documentation will be accepted by Medicare or other insurance company. I have been advised of my privacy rights pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

☐ Check here if you would like to receive electrodes supplies for 24 month

Patient/Legal Guardian Signature: _____ Date: _____