Advanced Pain Solutions, LLC _____
Accredited DME Provider
13730 Cypress Terrace Cir. Unit 401
Fort Myers, FL 33907
Phone (239) 275-7575 Fax (239) 275-7035

ATTENTION LUMBAR ORTHOTIC BRACE REQUEST

ATTENTION DOCTOR:
NAME:_____
_____
_____

REGARDING PATIENT:
NAME:_____
DOB: _____

PRESCRIBED ORTHOTIC: Date_____

[X] L0648: DDS 500 consists of a unique and patented expandable Traction Belt, Detachable Anterior and Posterior Panels and Hand Air Pump. DDS features a unique air pocket expansion system, and anterior and posterior rigid panels that help combine effective treatment, support and relief by reducing pressure within the vertebrae. By increasing the inter-vertebral disc space, pressure applied on the nerve root is relieved, thereby, eliminating pain while assisting active-rehabilitation. *The device is PDAC/ Medicare Approved.*

[ ] L0650: DDS Double is ideal for taller/ larger patients and provides additional support while decompressing the spine. *The device is PDAC/ Medicare Approved.*

Lumbar-sacral orthosis is covered when it is ordered for one of the following indications: (PLEASE CHECK ALL THAT APPLY)
[X] 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.
[X] To otherwise support weak spinal muscles and/or a deformed spine.

ESTIMATED LENGTH OF NEED (# of Months) _____ 1-99 (99 = Lifetime)

PLEASE CHECK ALL THAT APPLY:

ICD-10
[ ] M43.10 Spondylolisthesis, site unspecified
[ ] M47.817 Spondylosis lumbosacral
[ ] M47.819 Spondylosis site unspecified
[ ] M48.06 Spinal stenosis, lumbar region
[ ] M51.26 Disc bulge/herniation lumbar
[ ] M51.27 Disc bulge/herniation lumbosacral
[ ] M51.36 Disc degeneration lumbar
[ ] M51.37 Disc degeneration lumbosacral
[ ] M54.5 Lumbago - low back pain

ICD-10
[ ] M54.16 Radiculopathy, lumbar region
[ ] M54.17 Radiculopathy, lumbosacral region
[ ] M54.30 Sciatica, unspecified side
[ ] _____ Other
[ ] _____ Other

SUPPORTING DOCUMENTATION:
[ ] Imaging (X-Ray/ MRI Report)
[ ] Physical Examination
[ ] Oswestry Low Back Evaluation

Physician's Signature:_____ Date:_____
Printed Name:_____ NPI:_____
By signing above, I authorize the use of this document as a legal prescription and certify that lumbar orthosis is medically necessary and reasonable for the above patient. My office holds current patient medical records in support of this request.

PLEASE FAX REQUEST TO (239) 275-7035