PHYSICIAN ORDER FORM BIO-BACK LUMBAR ORTHOSIS

Physician Name:	NPI:
Phone:	Fax:

Patient Name:	DOB:	Insurance/HIC#:

URGENT

The Bio-Back can be covered if the coverage criteria are met. We ***are required by the patient's Medicare or Insurance to have the information below prior to shipping.***

PLEASE FAX THIS FORM AFTER IT IS COMPLETED, SIGNED AND DATED

ALL SECTIONS MUST BE COMPLETED

1 Lumbar orthosis is covered when it is ordered for one of the following indications:

Circle Y for *Yes*, N for *No*, D for *Does Not Apply*.

Y N D 1) To reduce pain by restricting mobility of the trunk; or

Y N D 2) To facilitate healing following an injury to the spine or related soft tissues; or

Y N D 3) To facilitate healing following a surgical procedure to the spine or related soft tissues;

Y N D 4) To otherwise support weak spinal muscles and/or a deformed spine.

2 Estimated Length of Need	O LIFETIME O Other: _____
3 ICD-9 DIAGNOSIS CODE(S)	

Prescribing physician, as noted above, must sign written order for Medicare/insurance to authorize payment. BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription, and certify that the lumbar orthosis is medically necessary and reasonable for the above patient. 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.

Signature _____ **Date** _____

Original signature required, no stamps permitted

No date stamps permitted