Vito's Pedorthic Center

Detailed Prescription / RX & Statement of Medical
Necessity For The Product By The Ordering Physician

Patient Name: _____ Patient Phone: _____ Patient DOB: _____

Insurance Information (Circle): Medicare Medi/Medi PPO Workers Compensation HCP Humana

Primary Insurance (with member ID): _____ Secondary Insurance (with member ID):_____

Qualifying Conditions: Diagnosis ICD/10 Code

1. _____ 3._____
2. _____ 4._____

Body Specification (circle one):

Right Side **Left Side** **Bilateral/Universal**

Estimated Length of Necessity: Number of Months _____ 1-99 (99 = Lifetime)

The doctor's chart notes must contain this required information

LOWER SPINE

☐ Aspen Scoliosis Bracing System L1005

Doctor's Initials: _____

☐ Aspen OTS LSO L0648

Doctor's Initials: _____

☐ Aspen OTS LSO L0650

Doctor's Initials: _____

☐ Aspen OTS TLSO L0457

Doctor's Initials: _____

Check the following that applies:

☐ To reduce pain by restricting mobility of the trunk.

☐ To faciliatate healing following an injury to the spine or related soft tissue.

☐ To facilitate healing following a surgical procedure on the spine or related soft tissue.

☐ Support weak spinal muscles and/or deformed spine.

KNEE BRACING

☐ OA Unloader + Knee Sleeve L1851 + L2397

Doctor's Initials: _____

☐ Hinged Brace + Knee Sleeve L1833 + L2397

Doctor's Initials: _____

☐ OA Unloader + Knee Sleeve L1844 + L2397

Doctor's Initials: _____

Perform Joint Laxity Test and Document in Chart Note

☐ I certify patient is ambulatory. Lachman test shows laxity & instability are present.

Doctor's Initial:_____

Check the following that applies:

☐ Anterior draw test is positive.

☐ Posterior draw test is positive.

☐ Varus Deformity

☐ Valgus Deformity

BRACING

☐ Elbow Brace L3760

Doctor's Initials: _____

☐ Wrist & Thumb Splint L3809

Doctor's Initials: _____

☐ OA Hip Brace L1690

Doctor's Initials: _____

☐ Cervical Brace L0174

Doctor's Initials: _____

☐ Dorsi-Assist AFO L1970+L2820+L2330

Doctor's Initials: _____

☐ Solid AFO L1960+L2820+L2330

Doctor's Initials: _____

☐ Walking Boot L4361

Doctor's Initials: _____

I have reviewed my patient's records and the items ordered above. I verify these products are medically necessary for my patient's current condition. I authorize the described items and the indicated frequency of use. I further verify that the diagnostic information provided is an accurate statement of the patient's condition as reflected in the patient's medical chart or file.

Physician Name: _____ LIC/NPI: _____

Office Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____

Physician Signature: _____ Date: _____ Rep: _____

PLEASE PROVIDE MEDICAL RECORDS WITH PRESCRIPTION

143 E. Rowland St. Suite # 2 - Covina, CA 91723 Toll Free: (626) 858 - 9460 Fax: (626) 858 - 9767