MI MED
Affordable Medical Supplies

# Orthopedic Bracing Physician Written Order

Phone: 248-648-0675
Fax: 248-618-1183
Email: Prescriptions@mi-med.com

Patient Name _____ Date of Birth _____ Diagnosis & DX Code _____ Phone _____

Primary Insurance _____ ID # _____ Secondary Insurance _____ ID # _____

## Knee

☐ACL Brace (OTS) L1845

☐ACL Brace (Custom)L1846*

*include Notes & LMN

☐OA Knee Unloader L1845

☐OA Single Upright L1843

☐ROM Hinged Knee L1833

☐Hinged Knee L1820

☐Patella Stabilizer L1820

☐Padded Knee Sleeve

## Upper Extremity

☐Shoulder Brace L3960

☐Abduction Shoulder Sling L3670

☐Elbow ROM L3760

☐Wrist Brace L3908

☐Wrist/Thumb L3809

☐Thumb Stabilizer

☐Tennis Elbow Support

## Lower Extremity

☐PF Night Splint L4397

☐Walking Boot L4387

☐OTS AFO L1951

☐Ankle Brace L1908

## Spinal

☐Lumbar Support L0648

☐Lumbar Support L0650
*with lateral stability*

☐Lumbar Support L0627

☐Thoracic Lumbar L0457

Wear Schedule: _____ Length of Need: ☐_____weeks ☐_____ months ☐ Lifetime

I certify that I have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers, and that the prescribed equipment is medically necessary. I have documented the following information and the need for this equipment in the patient's most recent chart notes. I certify that I am the practitioner identified on this form and that the information provided is true, accurate and complete to the best of my knowledge.

Printed Name of MD/DO/PA/NP _____ Authorizing Signature _____ Date _____ NPI _____

Address _____ Phone _____ Fax _____