



# Pain Rehab Products, Inc.

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## Prescription & Certificate of Medical Necessity

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Address: \_\_\_\_\_

Diagnosis Codes ICD-10 Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

### Lumbar Sacral Orthosis (LSO) and Thoracic Lumbar Sacral Orthosis (TLSO)

LSO L0642    LSO L0648    LSO L0650    TLSO L0457

Aspen Peak Scoliosis    DDS 500    DDS Max

Other: \_\_\_\_\_ HCPCS Code: \_\_\_\_\_

**Duration:** Patient has had this condition for \_\_\_\_ Months \_\_\_\_ Years

Length of Need:   Months \_\_\_\_\_ (99 = lifetime)

**Please indicate the following conditions that apply to the patient. Check all that apply.**

- To reduce pain by restricting mobility of the trunk.
- To facilitate 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.
- To otherwise support weak spinal muscles and/or a deformed spine.

### Physician Information

**I certify that the equipment and supplies I prescribed are Medically Necessary for this patient's well being. In my professional opinion, the equipment is both reasonable and necessary in reference to the accepted standards of medical practice and treatment for this patient's condition. It is NOT prescribed as convenience equipment. Substitution for this device is not allowed without my written approval.**

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Stamped Signatures are not acceptable)

Printed Physicians Name: \_\_\_\_\_ NPI #: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

### Required for ALL Medicare Patients

Chart Notes & Rx must be submitted together, Include chart notes supporting Medical Necessity (clinical documentation must support the continued need, use and benefit the device provides)

• **Patient Chart Notes Must Support the Following (LSO & TLSO):**

LSO or TLSO ordered must be documented in the medical record and all indications that are applicable above must ALSO be documented in the medical records. Include all chart notes supporting Medical Necessity. Clinical documentation must support the need, use and benefit that the LSO or TLSO provides.

**Along with this RX, please fax the patient's medical records, insurance card and demographics to (314) 832-1430. Pain Rehab Products, Inc. will provide the insurance pre-certification, patient fitting and follow-up.**