OCHOA'S PHARMACY

Prescriptions, Medical Equipment & Supplies

PH: (956) 381-0967 FAX: (956) 381-9844

DME PRESCRIPTION

Patient Name: _____ DOB: _____ Phone Number: _____

Address: _____

Date of Injury: _____ Chronic _____ Acute _____

Complaint Region(s): _____ Lumbar _____ Cervical Other: _____

Primary Insurance Co.: **BCBS AETNA CIGNA UHC HAS/HRA:**____ Other: _____ Insurance ID: _____

Spinal/Lumbar Protocol:	**Cervical Equipment:**	**Extremity Equipment:**
❑ TENS UNIT/Electrodes	❑ Cervical Collar Brace	❑ Rapid Knee Brace
❑ Universal Lumbar Brace	❑ Cervical Therapy Collar	❑ Ankle Brace
❑ Lumbar Conductive Garment	❑ Cervical Garment	❑ Shoulder Support
❑ Lumbar Posture Pump	❑ Cervical Posture Pump	❑ Wrist Brace/Cock-Up Splint
❑ Lumbar Chair Support	❑ Cervical Pillow	❑ Garment- Knee, Elbow
❑ Other:	❑ Other:	❑ Golfer's Elbow/Tennis Elbow
❑ Other:	❑ Other:	❑ Size: S M L XL XXL

Common Codes- Lumbar Diagnosis:

- ❑ M54.5 Low Back Pain
- ❑ M51.36 Disc Degeneration
- ❑ M48.06 Spinal Stenosis
- ❑ M54.16 Radiculopathy
- ❑ M99.03 Segmental & Somatic Function of Lumbar Region
- ❑ S33.5XXA Sprain of Ligaments
- ❑ Other: _____
- ❑ Other: _____

Common Codes- Cervical Diagnosis:

- ❑ M54.2 Cervicalgia
- ❑ M50.32 Disc Degeneration
- ❑ M48.02 Spinal Stenosis
- ❑ M54.12 Radiculopathy
- ❑ M99.01 Segmental & Somatic Function of Cervical Region
- ❑ S13.4XXA Sprain of Ligaments
- ❑ Other: _____
- ❑ Other: _____

Common Codes- Extremity Diagnosis:

- ❑ M76.50 Patellar Tendinitis
- ❑ M70.50 Bursitis of Unspecified Knee
- ❑ S83.429A Sprain of Lateral Collateral Ligament
- ❑ M99.06 Lower Extremity Segmental Dysfunction
- ❑ M25.579 Pain in Unspecified Ankle/Joint
- ❑ M75.30 Calcific Tendinitis, Unspecified Shoulder
- ❑ S43.409A Unspecified Sprain, Shoulder Joint
- ❑ M75.100 Rotator Cuff Syndrome
- ❑ G56.00 Carpal Tunnel Syndrome
- ❑ S63.519A Sprain of Carpal Joint
- ❑ M77.10 Lateral Epicondylitis, Unspecified Elbow
- ❑ M99.07 Upper Extremity Segmental Dysfunction
- ❑ Other: _____

Certificate of Medical Necessity:

I certify that the above prescribed item(s) are medically indicated and, in my opinion, is reasonable and necessary to effectuate a maximum and expedient recovery with reference to the standards of medical practice and treatment of this patient's condition. The above prescribed equipment is necessary and will make a meaningful contribution to the treatment of this patient's condition. This treatment is not in any way for general health, and is not for cosmetic purposes to improve appearance. Equipment frequency, duration, and length of time prescribed are indicated below. Goals included, but not limited to:

- ❑ Reduce Pain
- ❑ Reduce Muscle Spasm
- ❑ Promote Soft Tissue Healing
- ❑ Disc Hydration / Imbibition / Herniation /Joint Nutrition (posture pump)
- ❑ Increase Range of Motion
- ❑ Control Edema / Swelling
- ❑ Immobilization; Stabilization
- ❑ Conductive Garment: The Patient cannot manage without the use of a garment, due to there is such a large area to be stimulated, and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes.
- ❑ Post-Operative Pain / Surgical Procedure
- ❑ Reduce Reliance on Narcotics / Analgesics
- ❑ Traction to Correct Posture / Increase Flexibility

EQUIPMENT FREQUENCY / DURATION / LENGTH OF TIME PRESCRIBED:

Daily Frequency (circle)	**1-3 TIMES**	**3-5 TIMES**	**OTHER:**
Weekly Frequency (circle)	**DAILY**	**3-5 TIMES PER WEEK**	**OTHER:**
Prescription Length (circle)	**12-18 MONTHS**	**18-24 MONTHS**	**LIFETIME**

Physician Name (Please Print) **NPI**

Physician Signature **Date**