Miracle Medical Equipment & Supplies
502 East Expressway 83, Suite E
Weslaco, TX 78596
Ph. 866.969.9596 · Fax. 956.969.9569

PHYSICIAN'S ORDER FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION LEGIBLY. EFFECTIVE DATE: _____

PATIENT NAME: _____ HT: _____ WT: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT ID NUMBER (POLICY NUMBER) _____

PATIENT SECONDARY INSURANCE ID NUMBER _____

PATIENT'S DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE

DIAGNOSIS: _____

PLEASE CHECK REQUESTED ITEMS BELOW: ☐ RIGHT ☐ LEFT ☐ MEDIAL ☐ LATERAL

FOOT/ANKLE SUPPORT:
- ☐ L1902 AFO, ANKLE BRACE
- ☐ L1930 AFO, PLASTIC, PREFABRICATED
- ☐ L1971 AFO, ANKLE SUPPORT W/ ANKLE JOINT
- ☐ L4360 WALKING BOOT, PNEUMATIC
- ☐ L4350 ANKLE AIR SPLINT, AO, STIRRUP
- ☐ OTHER: _____

KNEE SUPPORT:
- ☐ L1820 KO, KNEE STABILITY BRACE
- ☐ L1832 TROM, KO, POST-OP BRACE
- ☐ L1843 HINGED KNEE OA SUPPORT BRACE
- ☐ L1845 HINGED KNEE ACTIVITY BRACE
- ☐ L1810/L2795 PATELLOFEMORAL BRACE
- ☐ OTHER: _____

CERVICAL/LUMBAR SUPPORT:
- ☐ L0120 CERVICAL COLLAR, PREFABRICATED
  - ☐ L0172 W/ HT ADJUSTMENT
- ☐ L0174 THORACIC EXTENSION COLLAR
- ☐ L0627 LUMBAR BACK SUPPORT BRACE
- ☐ L0631 LSO, BACK SUPPORT BRACE
- ☐ L0637 LSO, BACK SUPPORT W/ADD. PROFILE
- ☐ L0464 TLSO MOTION RESTRICTION BRACE
- ☐ OTHER: _____

WRIST/ELBOW SUPPORT:
- ☐ L3908 WRIST IMMOBILIZER, PREFABRICATED
  - ☐ L3807 W/ THUMB IMMOBILIZATION
- ☐ L3760 HINGED ELBOW SUPPORT BRACE
- ☐ OTHER: _____

SHOULDER SUPPORT:
- ☐ L3670 ARM SLING, ROM CONTROL &SUPPORT
- ☐ L3675 SHOULDER IMMOBILIZATION/STABILZER
- ☐ OTHER: _____

I, the undersigned, certify that the above prescribed equipment/medication is MEDICALLY NECESSARY for this patient's well being. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment".

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S NAME: _____ NPI #: _____

ADDRESS: _____

CITY, STATE, ZIP: _____ PHONE #: _____