

CA DOCTOR'S ORDER FORM (Rx) - MATERNITY ORTHOTICS

Patient Information:

Ship to: Home Clinic

Patient Name: _____ Phone: _____

Address: _____ Apt: _____ City/State: _____ Zip: _____

Insurance: Access AHPSC CCAH CCIPA CenCal CalOptima Direct CalViva Gold Coast HP

IEHP Partnership HP Imperial Health LA Care Noble IPA River City Sante Other _____

Member ID# (attach copy): _____ Date of Birth: _____

Ht: _____ Pre-pregnancy Wt: _____ lbs Pregnancy-related?: Y N Due / Delivery Date: _____

<input type="checkbox"/> Lumbar Support Belt (L0621) Dx: <input type="checkbox"/> Low back pain (M54.50) <input type="checkbox"/> Hip pain (M25.559) <input type="checkbox"/> Pelvic pain (R10.2) <input type="checkbox"/> Upper back pain (M99.02) <input type="checkbox"/> Other _____ <input type="checkbox"/> Spasm, tension, pain (M35.7)	<u>Size (circum. midway bet. hips & waist):</u> <input type="checkbox"/> Small (28"-33") <input type="checkbox"/> XL (41"-46") <input type="checkbox"/> Medium (33"-38") <input type="checkbox"/> 2XL (46"-51") <input type="checkbox"/> Large (38"-41")
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<input type="checkbox"/> Perineal V2 Support (L8300) Dx: <input type="checkbox"/> Vulvar varicosities (I86.3) <input type="checkbox"/> Petite (24-29) <input type="checkbox"/> Medium (32-37) <input type="checkbox"/> Perineal edema (I83.899) <input type="checkbox"/> Small (28-33) <input type="checkbox"/> Large (37-42)	<u>Hip Measurement (inches):</u>
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<input type="checkbox"/> Hernia Guard, double (L8310) Dx: <input type="checkbox"/> Umbilical Hernia Waist: _____ inches
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<input type="checkbox"/> Wrist Splint (universal) L3908 Dx: <input type="checkbox"/> Wrist Pain / Arthritis (M25.539) <input type="checkbox"/> Edema/Swelling (R60.1) <input type="checkbox"/> Carpal Tunnel Syndrome (G56.00) Circle: L R
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<input type="checkbox"/> Hip Brace / S.I. Belt (L1600) Dx: <input type="checkbox"/> Pubic symphysis separation (O71.6) <input type="checkbox"/> Enthesopathy of hip 726.5 <input type="checkbox"/> Pelvic joint pain (M25.559) <input type="checkbox"/> Other: _____	<u>Size (HIP measurement in inches):</u> <input type="checkbox"/> Petite (24"-32") <input type="checkbox"/> M (40"-48") <input type="checkbox"/> Small (32"-40") <input type="checkbox"/> L (48"-56")
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<input type="checkbox"/> Postpartum Binder (L0628) Dx: <input type="checkbox"/> Pendulous Abdomen (L91.9) Waist SIZE: _____ inches <input type="checkbox"/> C-Section (O82)

<input type="checkbox"/> Electric breast pump (E0603) Dx: <input type="checkbox"/> Lactation (Z39.1) <input type="checkbox"/> Engorgement (O92.29)

DECLARATION: I certify that this is true and medically necessary for the above patient. I have completely reviewed my patient's medical records and the items ordered. I understand that any falsification, omission, concealment of material fact may be subject to civil or criminal liability.

Provider Signature → _____

Date: _____

Provider Name & Address:

Full Name _____
 NPI _____
 Street Address _____
 City _____ State _____ Zip _____
 Contact _____ Phone _____

**PLEASE FAX TO:
1-888-518-7568**

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