ADVANCED
Home Medical, Inc.

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Customer Service: 1-800-230-4761
visit us at www.advancedhomemed.com

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:_____

❑ Lumbar Support Belt (L0621)

Dx:
- ❑ Low back pain (M54.50)
- ❑ Pelvic pain (R10.2)
- ❑ Other _____
- ❑ Hip pain (M25.559)
- ❑ Upper back pain (M99.02)
- ❑ Spasm, tension, pain (M35.7)

Size (circum. midway bet. hips & waist):
- ❑ Small (28"-33")
- ❑ Medium (33"-38")
- ❑ Large (38"-41")
- ❑ XL (41"-46")
- ❑ 2XL (46"-51")

❑ Perineal V2 Support (L8300)

Dx:
- ❑ Vulvar varicosities (I86.3)
- ❑ Perineal edema (I83.899)

Hip Measurement (inches):
- ❑ Petite (24-29)
- ❑ Small (28-33)
- ❑ Medium (32-37)
- ❑ Large (37-42)

❑ Hernia Guard, double (L8310)

Dx:
- ❑ Umbilical Hernia

Waist:_____ **inches**

❑ Wrist Splint (universal) L3908

Dx:
- ❑ Wrist Pain / Arthritis (M25.539)
- ❑ Carpal Tunnel Syndrome (G56.00)
- ❑ Edema/Swelling (R60.1)

Circle: L R

❑ Hip Brace / S.I. Belt (L1600)

Dx:
- ❑ Pubic symphisis separation (O71.6)
- ❑ Pelvic joint pain (M25.559)
- ❑ Enthesopathy of hip 726.5
- ❑ Other:_____

Size (HIP measurment in inches):
- ❑ Petite (24"-32")
- ❑ Small (32"-40")
- ❑ M (40"-48")
- ❑ L (48"-56")

❑ Postpartum Binder (L0628)

Dx:
- ❑ Pendulous Abdomen (L91.9)
- ❑ C-Section (O82)

Waist SIZE:_____ **inches**

❑ Electric breast pump (E0603)

Dx:
- ❑ Lactation (Z39.1)
- ❑ 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