FAX ORDER FORM

Patient Name: _____ DOB: _____ Phone: _____

SSN: _____ Sex: ☐ Male ☐ Female Email: _____

Address: _____

City: _____ State: _____ Zip: _____

1st Insurance: _____ Phone: _____

Policy Number #: _____ Group Number #: _____

2nd Insurance: _____ Phone: _____

Policy Number #: _____ Group Number #: _____

Alternate Contact: _____ Relationship: _____ Phone: _____

Prescriber's Name: _____ NPI #: _____

Phone: _____ Fax: _____ Email ID: _____

Address: _____

City: _____ State: _____ Zip: _____

Diagnosis: _____ Face-to-Face Visit Date: _____

Order Date: _____ Start Date: _____ Length of Need: _____

Electrotherapy Devices: ☐ TENS (E0730)

Orthopedic Braces: ☐ BACK BRACE (L0650) ☐ HINGED KNEE BRACE (L1851) ☐ ANKLE BRACE (L1902)
☐ WRIST + HAND BRACE (L3908) ☐ SHOULDER BRACE (L3670)

Compression Devices: ☐ PLASMAFLOW DVT (E0676) ☐ KNEE COMPRESSION SLEEVE (L2397)

Cervical Devices: ☐ TRACTION EQUIPMENT CERVICAL (E0849) ☐ CERVICAL MULTIPLE POST COLLAR (L0180)

DISCLAIMER:

If you do not receive all pages, please call the sender at the above number.

Physician Signature: _____ Date: _____