

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)

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Physician Signature: _____

Date: _____