ReVive Systems
700 N Santa Fe Ave
Edmond, OK 73003
Phone: 877-573-8378
Fax: 800-397-5143

Order Date: ____________________________

Patient's Name: ____ Date of Birth: ___________________________

Patient's Address: ____

City: ________________________ State: _________ Zip: __________ Patient's Phone: _______________________________

WRITTEN ORDER

I certify that the equipment listed below is medically necessary as part of the conservative care plan for this patient.

Bracing:

____ To reduce pain by restricting mobility of the trunk (MUST BE NOTED IN CLINICALS)

____ To facilitate healing following an injury to the spine or related soft tissue (MUST BE NOTED IN CLINICALS)

____ To facilitate healing following a surgical procedure on the spine or related soft tissue (MUST BE NOTED IN CLINICALS)

____ To otherwise support weak spinal muscles and / or a deformed spine (MUST BE NOTED IN CLINICALS)

______ LSO (Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs.)

______ TLSO (TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral discs.)

______ CSO (Cervical, multiple post collar, occipital/mandibular supports, adjustable.)

_____ Wrist   _____ Ankle   SIZE NEEDED: ___________   LEFT / RIGHT / BILATERAL

Knee Bracing:

______ Hinged Neoprene w/ Sleeve (Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf.)

______ Dual Instability w/ Sleeve   _____ Uni-OA Knee Brace w/ Sleeve: Varus / Valgus

SIZE NEEDED: ________________   LEFT / RIGHT / BILATERAL

OTHER PRODUCTS:

_____ CTU   The patient has a musculoskeletal or neurologic impairment requiring traction equipment; and the appropriate use of a home cervical traction device has been demonstrated to the patient and the patient tolerated the selected device. The treating physician orders and/or documents the medical necessity for greater than 20 pounds of cervical traction in the home setting.

_____ Other ____

ICD-10 CM Code(s): _______________ _______________ _______________ _______________ _______________

COVERAGE FOR CHRONIC PAIN:

Location of the pain: ____________________________ Severity of the pain: ____

Duration of time the patient has had the pain: ______________ Presumed etiology of the pain: _______________________

Prior treatments tried and results: ____

Yes	No	
✔	____	Does this equipment improve patient's functional mobility?
✔	____	This equipment is needed for an indefinite period of time (purchase)?

Physician's Name: ____ NPI #: ____

Physician's Signature: ____ Date: ___________________________

Signature Required – No Stamps

Order Start Date: ___________________________   Received Date: ___________________________