ADVANCED
Home Medical, Inc.

312 Paseo Tesoro ♣ Walnut CA 91789
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 ❑ Atlas ❑ CCAH ❑ CCIPA ❑ CenCal ❑ CalOptima Direct ❑ CalViva ❑ Gold Coast HP

❑ IEHP ❑ Partnership HP ❑ Imperial Health ❑ LA Care ❑ Noble IPA ❑ UPN ❑ Vivant ❑ 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 (R10.20)
- ❑ 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")
- ❑ 3XL (> 51")

❑ Perineal V2 Support (L8300)

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

Hip Measurement (inches):
- ❑ Petite (24-28")
- ❑ Small (28-36")
- ❑ Medium (36-44")
- ❑ Large (44-54")

❑ Hernia Guard, double (L8310)

Dx:
- ❑ Inguinal Hernia (low profile)
- ❑ Umbilical Hernia

Waist:_____ inches

❑ Wrist Splint (universal) L3908

Dx:
- ❑ Wrist Pain / Arthritis (M25.539)
- ❑ Carpal Tunnel Syndrome [ ] G56.00 [ ] G56.01 [ ] G56.02 [ ] G56.03
- ❑ 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

Confidentiality Notice: This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.