ADVANCED
Home Medical, Inc.

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

WA APPLE HEALTH ORDER FORM (Rx) - MATERNITY ORTHOTICS

Patient Information: **Ship to: ❑ Home ❑ Clinic**

Patient Name: _____ Phone: _____

Address:_____Apt:_____City/State:_____ Zip:_____

Insurance (attach copy): ❑ Apple Health ❑ CHPW ❑ Coordinated Care Health ❑ Molina ❑ Premera Blue Cross ❑ Wellpoint

Member / ProviderOne ID# (attach copy):_____ Date of Birth:_____

Ht:_____ Pre-pregnancy Wt:_____ lbs Pregnancy-related?: Y N Due / Delivery Date:_____

❑ Lumbar Support Belt
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")

❑ Perineal V2 Support
Dx: ❑ Vulvar varicosities (I86.3) ❑ Perineal edema (I83.899)
Hip Measurement (inches): ❑ Petite (24-29) ❑ Medium (32-37) ❑ Small (28-33) ❑ Large (37-42)

❑ Hernia Guard
Dx: ❑ Umbilical Hernia **Waist:_____ inches**

❑ Wrist Splint (universal) L3908
Dx: ❑ Wrist Pain [ ] M25.532 [ ] M25.531 ❑ Carpal Tunnel Syndrome ❑ RT (G56.01) ❑ LT (G56.02) ❑ BI (G56.03)
Circle: L R

❑ Blood pressure machine, auto
Dx: ❑ Gestational hypertension (O13.9) ❑ High risk pregnancy (O09.90)

❑ Hip Brace / S.I. Belt
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
Dx: ❑ Pendulous Abdomen (L91.9) ❑ C-Section (O82)
Waist SIZE:_____ inches

❑ Electric breast pump
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

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