ADVANCED
Home Medical, Inc.

312 Paseo Tesoro ♣ Walnut CA 91789
Customer Service: 1-800-230-4761

IL and MI DOCTOR'S ORDER FORM (Rx) - MATERNITY ORTHOTICS

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

Patient Name: _____ Phone: _____

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

Insurance (attach copy): ❑ McLaren ❑ Meridian Health ❑ Molina ❑ Priority Health ❑ United Health Community

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

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

❑ Lumbar Support Belt (Qty: 1)

Dx: ❑ Low back pain (M54.50)
❑ Other _____
❑ Hip pain (M25.559)
❑ Upper back pain (M99.02)
❑ Spasm, tension, pain (M35.7)

Size (circum. midway bet. hips & waist):
❑ Small (28"-33") ❑ XL (41"-46")
❑ Medium (33"-38") ❑ 2XL (46"-51")
❑ Large (38"-41")

❑ Perineal V2 Support (Qty: 1)

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, double (Qty:1)

Dx: ❑ Inguinal Hernia (low profile)
❑ Umbilical Hernia **Waist:_____ inches**

❑ Elastic Stockings (18-30 mmHg)

Diagnosis:
❑ Edema / Swelling (R60.1)
❑ Varicose Veins (I83.90)
❑ Venous Insufficiency (I87.2)
❑ Other _____
Quantity (circle): 1 2 pairs

Style/Type:
❑ Below Knee
❑ Above Knee / Thigh
❑ Pantyhose
❑ Maternity Pantyhose

Ankle Size:		Calf Size:
❑ 7"-8.25"	S	❑ 11"-15"
❑ 8.25"-9.5"	M	❑ 11.75"-16.5"
❑ 9.5"-10.75"	L	❑ 12.5"-18"
❑ 10.75"-12"	XL	❑ 13"-19"
❑ 12"-13.25"	XXL	❑ 13.5"-20"

❑ Wrist Splint (universal)

Dx: ❑ Wrist Pain / Arthritis (M25.539) **Circle: L R**
❑ Carpal Tunnel Syndrome ❑ RT (G56.01) ❑ LT (G56.02) ❑ BI (G56.03)

❑ Blood Pressure Kit, Auto (Qty: 1)

Dx: ❑ Hypertension (I10)
❑ Other:_____

❑ Hip Brace / S.I. Belt (Qty: 1)

Dx: ❑ Pubic symphisis separation (O71.6)
❑ Pelvic joint pain (M25.559)
❑ Other:_____

Size (HIP measurment in inches):
❑ Petite (24"-32") ❑ M (40"-48")
❑ Small (32"-40") ❑ L (48"-56")

❑ Abdominal Binder (Qty: 1)

Dx: ❑ Pendulous Abdomen (L91.9)
❑ C-Section (O82)
Waist Size (pre-preg) _____ inches

❑ Electric breast pump (Qty: 1)

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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