

**DETAILED WRITTEN PHYSICIAN ORDER
WRIST-HAND-FINGER ORTHOSIS**

SECTION A – to be filled out by the supplier

CERTIFICATION: () INITIAL () REVISED

SUPPLIER: ORTHO-TEC MEDICAL, INC.
P.O. BOX 364

PATIENT: _____

WEBSTER, MA 01570-0364
(888) 616-9811
PROVIDER #: 0995830001

DOB: _____ SEX: _____

NPI #: 1154328078

HIC #: _____

DATE OF SERVICE: _____

FACILITY: _____

PRODUCT ORDERED:

() RIGHT () LEFT

PHONE #: _____

Wrist-Hand-Finger Orthosis

HCPCS : L3807; 100% warranty

INDICATIONS: Flexion contracture of the hand (718.44)

SECTION B – to be filled out by the Physician, Physician's employee or professional staff

DIAGNOSIS (ICD-9): _____ ; _____ ; _____ ; _____ ; _____

EFFECTIVE DATE OF ORDER: _____

ESTIMATED LENGTH OF NEED (# mo.): _____ (6-99; 99=lifetime)

MEDICAL NECESSITY:

I certify the medical necessity of these items for this patient. Section B of this form and any statement on my letterhead attached hereto has been completed by me or my employee or completed by a third party and reviewed by me. The foregoing information is true, accurate and complete, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

PHYSICIANS NAME, ADDRESS & TELEPHONE:

NAME: _____

TELEPHONE: _____

ADDRESS: _____

FAX: _____

PHYSICIANS SIGNATURE: _____ *DATE:* _____ *NPI#:* _____