DWO for Dynamic Splints

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622

DATE OF ORDER:_____

DATE OF LAST FACE TO FACE:_____

PATIENT INFORMATION

First Name_____ **Last Name**_____

Address_____ **City**_____ **State**_____ **Zip**_____ **Phone**_____

Date of Birth_____ **Emergency Contact**_____ **Emergency Contact Phone**_____

REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name_____ **Therapist Name** _____

Clinic Address_____ **City**_____ **State**_____ **Zip**_____

Phone_____ **Fax**_____

PRODUCT PRESCRIBED

	Check Item:	MUST CIRCLE ONE:	Billable HCPCS:	MUST CIRCLE ONE:
☐	JAS EZ Elbow	Right or Left or Both	L3740	Flexion or Extension or Both
☐	Dynamic Elbow	Right or Left or Both	E1800	Flexion or Extension or Both
☐	JAS EZ Pro/Sup	Right or Left or Both	L3766	Pronation or Supination or Both
☐	Dynamic Pro/Sup	Right or Left or Both	E1802	Pronation or Supination or Both
☐	JAS EZ Wrist	Right or Left or Both	L3905	Flexion or Extension or Both
☐	Dynamic Wrist	Right or Left or Both	E1805	Flexion or Extension or Both
☐	JAS EZ Knee	Right or Left or Both	L1844	Flexion or Extension or Both
☐	Dynamic Knee	Right or Left or Both	E1810	Flexion or Extension or Both
☐	JAS EZ Ankle	Right or Left or Both	L1970	
☐	Dynamic Ankle	Right or Left or Both	E1815	
☐	JAS EZ Shoulder	Right or Left or Both	L3973	
☐	JAS EZ Finger		L3935	Flexion or Extension or Both
☐	JAS EZ Toe		E1399	Flexion or Extension or Both

DIAGNOSIS

Primary ICD10 Numeric Code:_____ **Secondary ICD10 Numeric Code:**_____

PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to The current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried or considered and ruled out.

Physician Name_____ **NPI#**_____ **Phone**_____ **Fax**_____

Physician Address_____ **City**_____ **State**_____ **Zip**_____

Physician Signature_____ **Date Signed**_____