PHYSICIAN'SPRESCRIPTIONFORM - POSTPARTUM THERAPY

PATIENT INFORMATION

Full Legal Name: ______________________________

Home Address: ______________________________

Date of Birth: ______________ Home or Cell Number: ______________

Email address: ______________________________

Primary Insurance: ______________ Insurance ID: ______________

DIAGNOSIS & PRODUCTS (PLEASE SELECT ALL THAT APPLY)

Diagnosis:	**ICD10**	
Postpartum Care System	**Mama Strut L8310** Please place a check next to the size needed for the patient. *When sizing, we recommend measure the top of the patient's hip bone (Iliac crest) for sizing.*	
	______ X-Small (26"-32") ______ Medium (35"-42") ______ X-Large (42"-48") ______ 3X-Large (54"-60")	______ Small (32"-37") ______ Large (38"-45") ______ 2X-Large (48"-54") ______ 4X-Large (60"-64") A9273 Abdominal Ice/Heat pack ______ (additional) A9273 Lower Back Ice/Heat pack ______ (additional) Extender needed ___Yes ___ No

PHYSICIAN INFORMATION

Physician Name: ______________________________

Office Address: ______________________________ **NPI #:** ______________

______________________________ **Phone #:** ______________

______________________________ **Fax#** ______________

PHYSICIAN'S SIGNATURE: ______________________ **Date:** ______________

This document is not intended to be a substitute for the comprehensive medical record.
Per Medicare guidelines, this form must be supported with information in the format used for other chart entries.