Fax orders to (817)473-1839 or email imsexpertsintake@att.net

Rep Name: _____

IMS Experts
Physician Detail Written Order and Letter of Medical Necessity (LMN)
TLSO Brace

PATIENT NAME:		**ICD-10 / DX:**	
DOB:		**HCPC CODE:**	
PHYSICIAN:		**NPI:**	
PHYSICIAN PH #:		**MED LICENSE:**	

These prescribed durable medical equipment product(s) are for treatment of the referenced patient. It is both reasonable and medically necessary to effectuate a maximum and expedient recovery.

TLSO BRACE INDICATIONS FOR PRESCRIBED PT: choose ONE OPTION (option 1, 2 or 3)

◯ **Option 1 -TLSO BRACE SURGICAL PRE-DELIVERY**: (select one or all that apply for patient)
◯ to reduce pain by restricting mobility to the trunk.
◯ to facilitate healing following an injury to the **spine or related soft tissue** (circle one)
◯ to otherwise support **weak spinal muscles OR deformed spine** (circle one)

◯ **Option 2 - TLSO BRACE SURGICAL POST-DELIVERY** Pt requires brace:
◯ to facilitate healing following an injury to the **spine or related soft tissue** (circle one)

◯ **Option 3 - TLSO BRACE NON SURGICAL** Pt requires brace:
◯ to reduce pain by restricting mobility to the trunk.
◯ to facilitate healing following an injury to the **spine or related soft tissue** (circle one)
◯ to otherwise support **weak spinal muscles OR deformed spine** (circle one)

Type of Brace/Manufacturer issued to patient:_____ Qty:_____
Date of Order:_____ Patient Start Date:_____
Length of Need: (check **one**) ◯ 99 months/lifetime ◯ Rental ◯ Other duration_____

X_____ Date_____
Physician Signature (NO STAMP)

This information will become part of the dictation and permanent clinical record of the above patient.