PRESCRIPTION FORM

EMAIL: info@mcbdme.com
FAX: 973-689-6120

DATE: ____/____/____

MCB DME
Your Therapeutic Brace Authority

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Phone (___) ____-_____

Street Address: _____

City: _____ State: _____ Zip: _____

STIM UNIT / CONDUCTIVE GARMENTS

STIM UNIT . E0745
☐ Other_____

BACK GARMENT . E0731
☐ M54.16 Radiculopathy, Lumbar
☐ M51.26 Lumbar Bulging Disc
☐ Other_____

KNEE GARMENT . E0731
☐ M17.11 Osteoarthritis, Right Knee
☐ M17.12 Osteoarthritis, Left Knee
☐ M25.362 Knee Instability
☐ Other_____

SHOULDER GARMENT . E0731
☐ M19.211 Osteoarthritis, Right
☐ M19.212 Osteoarthritis, Left
☐ M75.41 Impingement, Right
☐ M75.42 Impingement, Left
☐ Other_____

NECK GARMENT . E0731
☐ M54.2 Cervicalgia
☐ S16.1XXA Strain of Neck Muscle
☐ Other_____

ELBOW GARMENT . E0731
☐ M25.521 Right Elbow Pain
☐ M25.522 Left Elbow Pain
☐ M70.21 Right Elbow Burcitis
☐ M70.22 Left Elbow Burcitis
☐ Other_____

SOCK GARMENT . E0731
☐ M19.071 Osteoarthritis, Right Ankle
☐ M19.072 Osteoarthritis, Left Ankle
☐ M72.2 Plantar Fasciitis
☐ E1140 DM Neuropathy
☐ Other_____

GLOVE GARMENT . E0731
☐ G56.01 Carpal Tunnel Syndrome, Right
☐ G56.02 Carpal Tunnel Syndrome, Left
☐ M19.031 Osteoarthritis, Right Wrist
☐ M19.032 Osteoarthritis, Left Wrist
☐ Other_____

THERAPEUTIC BRACES

LUMBAR SACRAL BRACE . L0648/L0631
☐ M54.16 Radiculopathy, Lumbar
☐ M51.26 Lumbar Bulging Disc
☐ Other_____

THORASIC LUMBAR SUPPORT . L0456/L0457
☐ M54.16 Radiculopathy, Lumbar
☐ M54.14 Thorasic Radiculopathy
☐ Other_____

CERVICAL COLLAR . L0180
☐ M54.2 Cervicalgia
☐ 2W32x32 Immobilization of Neck Using Brace
☐ Other_____

CORRECTIVE KNEE BRACE . L1832
☐ M17.11 Osteoarthritis, Right Knee
☐ M17.12 Osteoarthritis, Left Knee
☐ M25.362 Knee Instability
☐ Other_____

WRIST/HAND BRACE . L3916/L3915
☐ G56.01 Carpal Tunnel Syndrome, Right
☐ G56.02 Carpal Tunnel Syndrome, Left
☐ M19.031 Osteoarthritis, Right Wrist
☐ M19.032 Osteoarthritis, Left Wrist
☐ Other_____

PRESCRIBING PHYSICIAN

Last: _____ First: _____ NPI #: _____ Phone (___) ____-_____

Signature: _____ Date: _____/_____/_____

Please include the following with prescription: Patient Demographics (Name, Address, Date of Birth, etc.); Copy of Insurance cards (Primary and Secondary, if applicable); Chart Notes clearly stating the need for a Stim, Garment and/or Therapeutic Brace.