185 Grove Street Waterbury, CT
T: 203-575-0199 ◆ F: 203-575-0515
www.StollsPharmacy.com ◆ Email: info@StollsPharmacy.com

Back Brace

Patient Name: ____ Date of Birth ____/____/____

Patient Street Address: _____________________________________ City, ST, Zip: ____________________

Dear Prescriber,

Stoll's Pharmacy, Inc. is in receipt of an order placed by you or your staff to provide services for your patient listed above. The information below is a written confirmation of this order. **Please fill in all pertinent information as well as modify any incorrect entries so that your patient receives their full medical insurance benefit.**

Order Start Date: __________________

Description of item ordered:

[ ] Lumbar orthosis (L-1 to below L-5)
[ ] Lumbar-sacral orthosis
(Sacrococcygeal junction to T-9)
[ ] Other: *(please describe in detail)*

Modifications: *(select one)*

[ ] None
[ ] Flexible stays
[ ] Sagittal control, rigid anterior and posterior panels
[ ] Sagittal control, rigid posterior panel only

Indications: *(check all that apply)*
[ ] To reduce pain by restricting mobility of the trunk
[ ] To facilitate healing from injury to the spine or related soft tissues
[ ] To facilitate healing following a surgical procedure on the spine or related soft tissues
[ ] To otherwise support weak spinal muscles and/or a deformed spine

Diagnosis (**ICD-10-CM Code**):

Length of Need:

Please complete and sign below to indicate your acceptance of the above information and return the original form to us in the envelope provided. If you have any questions, please contact us at (203) 575-0199

Doctor Name: ____ **Prescriber NPI #:** _______________________

Street Address: ____________________________________**City, ST, Zip** ______________________________

Signature: ____ **Date Signed:** ____/____/___
SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED BY INSURANCE COMPANIES

Signing Prescribers NPI # (If Different from above) _______________________________________