NEUROPATHWAYS

Substantial *PAIN RELIEF* with Unparalleled Support
Fax form and prescription and insurance to : 800-605-4025

ORDER FORM FOR BACK BRACES AND CERVICAL TRACTION

Please be advised the specific item(s) below are medically necessary to ensure effective treatment of the patient listed on this form. Any alteration from this prescription may hinder patient's recovery.

Patient Name: _____

Patient Phone #: _____

Patient Address: _____

City: _____

State: _____ Zip: _____

Date of Birth: _____

Social Security #: _____

I am prescribing the following product(s) for my patient:

Cervical Traction Unit _____

Back Brace _____

Life Force Power Cushion _____

SystemLOC Unit Measurements: Waist at Navel: _____

Pelvic: _____

(I/PT, need PT name as well as referring MD info)

Physical therapist's name if applicable: _____

PT's ph# if applicable: _____

PT Clinic Name _____

Physician Name: _____

Physician Address: _____

City: _____

State: _____ Zip: _____

Physician Phone: _____

Physician NPI#: _____

Physician Signature: _____

Date: _____

Diagnosis:	ICD-9 Codes(s):
Lumbar:	
Degenerative Disc Disease (L, L/S):	722.52
Herniated Disc (Lumbar)	722.10
Radiculopathy:	729.2
Sciatica:	724.3
Spondylolisthesis (aquired)	738.4
Spondylolisthesis (congenital):	756.12
Spondylolysis (aquired):	738.4
Spondylolsis (congential):	756.11
Facet Syndrome:	724.8
Chronic Lumbar Strain:	847.2
Acute Strain and Instability (L/S or S/I):	724.6
Spinal Stenosis (L or L/S):	724.02
Laminectomy, Post Laminectomy Synd (L):	722.83
Osteoporosis:	733.00
Osteoarthritis/Spondylosis (L/S):	721.3
Spinal Fusion (Lumbar):	V45.4
Lumbago:	724.2
Myospasm:	728.85
Paresthesia:	782.0
Other, please specify:	
Cervical	
Degenerative Disc Disease:	722.4
Herniated Disc:	722.0
Spinal Stenosis:	723.0
Spondylolysis:	721.0
Cervical Sprain/Strain	847.0
Neck Pain:	723.1
Cervical Radiculopathy:	723.4
Myospasm:	728.85
Paresthesia:	782.0
Other, please specify:	

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