

PRESCRIPTION

LSO Brace

by Medical Science Products, Inc.

PATIENT'S NAME: _____

DIAGNOSIS/ICD9 CODE(S): _____

I certify that the LSO BRACE is medically necessary as part of my treatment of this patient. The prescribed device is reasonable and necessary for the treatment of this patient's condition.
NO SUBSTITUTIONS.

PHYSICIANS SIGNATURE

Date

Please Print: _____

Facility Name and Address

Physician Name and NPI Number

Contact Phone Number

Thank You.

Fax Prescription and Patient Information to:
Medical Science Products, Inc.
Fax: 330-854-1953
Tel: 330-854-4060