

****Please attach face sheet w/ patient demographics & insurance info****

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: Male Female

DIAGNOSIS

Primary Diagnosis

ICD-10 Code: _____

Secondary Diagnosis

ICD-10 Code: _____

Height: _____ Weight: _____ Start Date ____/____/____

PRODUCT SELECTION

Knee

Patella Tracking Knee
 XS S M L XL 2XL

Knee Sleeve w/ hinge
 XS S M L XL 2XL

Knee Immobilizer
 14" 18" 24"

ROM Knee
 XS S M L XL 2XL

Foot and Ankle

Lace-up Figure 8 Ankle Brace Shoe Size: _____
 XS S M L XL

Ankle Stirrup
 Pediatric Regular

Cam Boot
 Tall Short Shoe Size: _____

Night Splint
Shoe Size: _____

Wrist/Hand/Thumb

Cock-Up Wrist
 Left Right Pediatric

Cock-Up Wrist hand w/ Thumb Spica
 Left Right Pediatric

Boxer Splint
 Left Right Pediatric

Thumb Spica, no wrist
 XS S M L XL

CMC with Wrist
 XS S M L XL

Elbow

Bandit Tennis Elbow

Hinged Elbow Sleeve
 S M L XL

Shoulder

Shoulder Immobilizer
 XS S M L XL

REFERRAL INFORMATION

Practice Name: _____ Fax: _____

Office Address: _____ Email: _____

Phone: _____ Preferred Method of Contact? Phone Fax Email

Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (____) _____ - _____ Ext. _____

Physician Signature: _____ Date: ____/____/____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: _____ Date: ____/____/____

Call 1.855.201.3724 or visit www.chcsolutions.com for additional information.