Total Healthcare Solutions, LLC
7048 Old Canton Rd Ste 2E | Ridgeland, MS 39157
Phone: 601.919.0972 | Toll Free: 866.919.0972

Fax Completed Forms To: 601.919.0974

Durable Medical Equipment Prescription

Patient Name: _____ **DOB:** _____ **Ht:** _____ **Wt:** _____ **Waist:** _____

Address: _____ **City:** _____ **St:** _____ **Zip:** _____

Phone: _____ **SS#:** _____ **Gender:** **M** **F**

Primary Insurance: _____ **Policy #:** _____

Secondary Insurance: _____ **Policy #:** _____

Assignment of Benefits: *I request that payment of authorized insurance benefits be paid directly to the above named company for any lifetime services furnished to me by that supplier. I authorize the release of any of my medical or other information needed to determine benefits payable for related services to Total Healthcare Solutions and its agents by the holder of such information. Total Healthcare Solutions may forward/copy my records to medical professionals related to my care. I am responsible for balances not covered by insurance. I understand any products received cannot be returned if opened.*

Patient/Authorized Signature: _____ **Date:** _____

Prescribed Item

☐ Hip Brace (L1686)

☐ Left Hip
☐ Right Hip

Left	ICD-10 Diagnosis	Right
☐ Z96.642 Presence of left artificial hip joint		☐ Z96.641 Presence of right artificial hip joint
☐ M87.852 Avascular Necrosis (Osteonecrosis) left hip		☐ M87.851 Avascular Necrosis (Osteonecrosis) right hip
☐ S72.92XA Fracture of left femur, unspecified		☐ S72.91XA Fracture of left femur, unspecified
☐ M16.12 Unilateral primary osteoarthritis of left hip		☐ M16.11 Unilateral primary osteoarthritis of right hip
☐ M24.052 Loose body in left hip		☐ M24.051 Loose body in right hip
☐ M24.152 Other articular cartilage disorders in left hip		☐ M24.151 Other articular cartilage disorders in right hip
☐ Other: _____		☐Other: _____

Length of Need: _____ **months (lifetime = 99)** **Start Date:** _____ **Place of Service:** _____

I certify that I am the physician identified on this form. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. Per insurance guidelines, I will maintain the order and agree to provide copies of the supporting medical records as requested for any insurance review. Said information will be sent to Total Healthcare Solutions, LLC, who will verify insurance and contact the patient for follow-up questions and information.

Physician/FNP Name (Print): _____ **NPI:** _____

Address: _____ **City:** _____ **St:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Physician/FNP Signature: _____ **Date:** _____