ALL STAR MEDICAL

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Prescription Form

PATIENT NAME ____________________

DATE OF BIRTH ____________________

PATIENT PHONE ____________________

ICD-10 CODE ____________________

DIAGNOSIS ____________________

PHYSICIAN NAME ____________________

PHYSICIAN NPI# ____________________

FACILITY NAME ____________________

ADDRESS ____________________

____

CITY ____________________

STATE ____________ ZIP ____________

OFFICE PHONE ____________________

OFFICE FAX ____________________

Prescribed Product

GALAXY ANKLE BRACE-L1971 ✓

QUICKSILVER KNEE BRACE-L1832, L1833 ✓

GALAXY WRIST BRACE-L3916 ✓

PAIN BUSTER KNEE BRACE-L1832,L1833 ✓

✓ LEGEND X 637 LUMBAR PAIN RELIEVER-L0637, L0650

✓ LEGEND X 639 SPINAL ORTHOSIS-L0639, L0651

✓ LEGEND X 631 SPINAL ORTHOSIS-L0631, L0648

Required Length:

ADDITIONAL COMMENTS ____________________

It is my expert opinion that the product indicated for the above-named patient is medically reasonable and necessary to facilitate management of this patient's diagnosis. Please dispense as written.

PHYSICIAN/PROVIDER SIGNATURE ____________________ DATE ____________
(WITH CREDENTIALS)

Dispense as Written. No Substitutions.