AIM PLUS
MEDICAL SUPPLIES

Certificate of Medical Necessity of Certifying Provider for Wrist, Hand, & Finger Orthosis

Please fax form with Provider's Signature to 866-496-7054

PATIENT INFORMATION

Name: _____ Date of Birth ____/____/_____
Primary Phone: _____ Secondary Phone: _____
Address: _____ City/State/Zip: _____
Primary Insurance: _____ ID#: _____
Secondary Insurance: _____ ID#: _____
Contact Person (If other than Patient): _____

It is my expert opinion that HCPCS Code L3809 is medically necessary for the following reason(s). This prescription also acts as a Letter of Medical Necessity. (Check all that apply)

___ To reduce pain by restricting mobility of the wrist, hand, & finger joints.
___ To facilitate health and reduce pain following an injury to the wrist, hand, & finger or related soft tissues.
___ To facilitate health and reduce pain following a procedure on the wrist, hand, and finger or related soft tissues.
___ To otherwise support weak wrist, hand, & finger muscles/joints and/or a deformed wrist, hand, & finger.

Please choose ICD-10 codes that apply. Check all that apply.

___ G56.01 Carpal Tunnel Syndrome (R)
___ G56.02 Carpal Tunnel Syndrome (L)
___ M19.031 Osteoarthritis, Wrist (R)
___M19.032 Osteoarthritis, Wrist (L)
___ M19.041 Osteoarthritis, Hand (R)
___M19.042 Osteoarthritis, Hand (L)
___ M65.4 Radial Styloid Tenosynovitis
___S62.009A Scaphoid Fracture
___ S63.649A Thumb RCL Injury
___ Other _____

Duration: Patient has had this condition for a period of ____ month(s) ____ year(s). (Chronic = 3 months or more)
Estimated Length of Need ___ month(s) ____ 1-99 (99 = Lifetime)

This patient is being treated under a comprehensive plan of care for arthritis/pain. I, the undersigned, certify that above prescribed is medically necessary for the patient's overall well-being. In my opinion, the following orthotic/arthritic relief products are both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be made available upon request.

Requested Product:

___ Thumb Spica Wrist Brace ____ XS ___ S ___ M ___ L ___XL
___ Lycra Lined Wrist Brace with Thumb Spica ____ XS ___ S ___ M ___ L ___XL
___ Universal Wrist Brace with Thumb Spica ___ Right Universal ___Left Universal
___ Thumbkeeper Support with D-Ring. ___ Small ___ Medium ___ Large
___ Thumb Spica Orthosis ___ Small ___ Medium ___ Large
___ Wrist Hand Thumb Orthosis ___ Small ___ Medium ___ Large
___ Other product _____
Please indicate: ___ Right ___Left ___Both

Provider Name (Print): _____ Provider NPI# _____
Provider Phone Number: _____ Provider Fax: _____
Provider Signature: _____ **Date**: _____