Please attach a patient demographic sheet and copies of the front and back of the insurance card

Last Name:____________________ **First Name:** ____________________ **Date of Birth:**__________

Email:____________________ **Phone #**____________________ **Cell/ Alternate #:**__________

Address:____________________ **City:**__________ **State:**____ **Zip:**________

Primary Insurance:____________________ **ID#:**____________________

Primary Insurance Phone:____________________ **Address:** ____________________

Secondary Insurance:____________________ **ID#** ____________________

Secondary Insurance Phone: ____________________ **Address:** ____________________

Brace: **Calibrace+ TLSO** HCPC: **L0457**

Diagnosis:

Please select Parkinson's Disease (when applicable):	Please select at least one applicable code:
☐ **G-20 Parkinson's Disease**	☐ **M54.5 Low back pain**
	☐ **M81.0 Age-related osteoporosis without current pathological fracture**
	☐ **M48.06 Spinal stenosis, lumbar region**
	☐ **M48.07 Spinal stenosis, lumbosacral region**
	☐ **M41.45 Neuromuscular scoliosis, thoracolumbar region**
	☐ **M41.46 Neuromuscular scoliosis, lumbar region**
	☐ **M41.47 Neuromuscular scoliosis, lumbosacral region**
	☐ **Other Diagnosis:**

A spinal orthosis (L0457) is covered when it is ordered for one of the following indications, please check all that apply:

☐To reduce pain by restricting mobility of the trunk; or
☐To facilitate healing following an injury to the spine or related soft tissues; or
☐To facilitate healing following a surgical procedure on the spine or related soft tissue; or
☐To otherwise support weak spinal muscles and/or a deformed spine.

This Product is a part of my regimen, indicated, reasonable and medically necessary for treatment of the physical condition of my patient.

Print Practitioner Name:____________________ NPI:____________________

Women's Sizing Chart

Size:	XS	S	M	L	XL
Hip:	Under 27”	27” - 30”	30” - 36”	36” - 39”	39” - 43”

Men's Sizing Chart

Size:	XS	S	M	L	XL
Waist:	Under 27”	27” - 30”	30” - 36”	36” - 39”	39” - 43”

*Please measure at the true waist (2 fingers above the belly button) for accurate measurement. The waist measurement is NOT the pant size measurement)

Address:________________________________City:________________State:_________ Zip:__________

Phone:__________________________________Fax:____

Signature of Physician, Physician Assistant or Nurse Practitioner: **Date:**

____ ________________________

Please include patient notes pertaining to the Calibrace+ and email this completed form to orders@abililife.com

Or Fax this form to 844-335-8496

[ATTACH PATIENT NOTES INDICATING A NEED FOR THE CALIBRACE+]