Physician's Written Order

Total Pelvic Support System

Mama Strut™ by PELV-ICE

Due Date _____/_____ /_____

Patient Info

First: _____ Last _____ MI _____ Patient DOB: _____/_____/_____ Gender ☐ M ☐ F

Address: _____ Phone #: _____

City: _____ State: ____ ZIP: _____ E-mail Address: _____

Doctor Info

Prescribing Physician Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NPI #: _____

Insurance

Primary Insurance: _____

Policy/ID #: _____

Group #: _____

Phone #: _____

Secondary Insurance: _____

Policy/ID #: _____

Group #: _____

Phone #: _____

Diagnosis

- ☐ R10.2 - Pelvic and Perineal Pain
- ☐ I86.3 - Vulvar varices, Injury of the external genitalia
- ☐ O26.7 – Subluxation of symphysis (pubis) in pregnancy, childbirth & puerperium
- ☐ 071.89 – Diastasis recti
- ☐ K40-46 – Hernia
- ☐ O70.0-O70.4 – Perineal laceration during delivery
- ☐ M54.5 – Acute or chronic pain in the lumbar or sacral region
- ☐ M25.551/M25.552 – Hip pain R/L
- ☐ S30.23 – Vulvar/Vaginal hematoma
- ☐ R10.30 – Lower Abdominal, inguinal, groin pain
- ☐ N81 – Female genital prolapse
- ☐ Other:_____
- ☐ Other:_____

Duration of need: _____months

(99 = Lifetime)

Use Y for Yes, N for No:

_____ Did the patient have a 3rd or 4th degree vaginal tear with a previous delivery?

_____ Did the patient have a breakdown of the suture, opening of skin with infection in a previous delivery?

_____ Did the patient have an episiotomy with a previous delivery?

_____ Did the patient have a rectal fissure repaired after delivery?

_____ Did the patient have a prolonged recovery from a vaginal tear in a previous delivery?

_____ Did the patient have a prior c-section with wound infection and/or wound disruption?

_____ Does the patient have diastasis or hernia from a prior c-section or vaginal delivery?

_____ Did the patient suffer with recurrent/persistent low back pain with this pregnancy?

_____ Does the patient have a BMI over 30 with an increased wound infection risk?

_____ Does the patient have severe diabetes and a history/or increased risk for wound infections, slow healing wounds?

_____ Does the patient have genital prolapse?

_____ Does the patient have a history of hemorrhoids?

_____ Does the patient suffer from pelvic floor dysfunction or incontinence?

Products

Check one & Appropriate Size

☐ Medical Grade Mama Strut Postpartum Care System

XXS XS S M L XL 2XL 3XL 4XL

Postpartum/Post-op: 8" wide medical grade quality, latex free, anti-microbial abdominal, pelvic-sacral and lumbar support secured by attached compression shorts for maximum stability with 3 attached and adjustable pelvic floor/perineum/hernia elastic tension straps. Use with or without adjustable tension straps to customize placement and amount of support. Removable and adjustable pouch with gel packs for cryotherapy or heat therapy in combination with compression to reduce pain, swelling and pressure for the lumbar, hips abdomen and perineum. Latex free.

☐ Medical Grade Mama Strut Antenatal Care System

XXS XS S M L XL 2XL 3XL 4XL

Antenatal: 4" wide medical grade quality, latex free, anti-microbial abdominal, pelvic-sacral and lumbar support secured by attached compression shorts for maximum stability with 3 attached and adjustable pelvic floor/perineum/hernia elastic tension straps. Use with or without adjustable tension straps to customize placement and amount of support. Removable and adjustable pouch with gel packs for cryotherapy or heat therapy in combination with compression to reduce pain, swelling and pressure for the lumbar, hips and perineum. Relieves lumbar-pelvic muscles and ligaments strain by transferring the weight of the abdomen to the spine. Lifts and supports the abdomen and pelvic floor, reducing pelvic pressure and pain and improving circulation. Latex free.

HCPCS

E1399: Long Description: PELVIC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, PROVIDES LUMBAR SUPPORT, PROVIDES PELVIC FLOOR/PERINEAL SUPPORT, PROVIDES ABDOMINAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, HIP JOINT, ADJUSTABLE FLEXION, EXTENSION, ABDUCTION CONTROL, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE PELVIS, LUMBAR, ABDOMINALS AND PELVIC FLOOR. INCLUDES REMOVABLE POUCHES WITH GEL PACKS FOR ICE/HEAT THERAPY ON THE LUMBAR, HIPS, ABDOMINALS AND PERINEUM.

I certify that I am the physician/practitioner identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and physician notes and other supporting documentation will be provided to CompCare Health, Inc. upon request. I understand any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician Signature : _____ Date: _____ Printed Name: _____

(STAMPS NOT ACCEPTABLE)

NPI #: _____