7083 Hollywood Blvd., 4th Fl
Los Angeles, CA 90028
www.mamastrut.com

Phone: (844) 370-1858 or (310) 961-3626 **Fax:** (424) 293-1283

facsimile transmittal

To:		Fax:	
From:	Mama Strut	Date:	
Re:	PWO and Clinical Notes Needed	Pages:	3

CONFIDENTIAL

Attention Health Care Provider:

We have received a request to bill your patient's insurance for one of our pelvic support systems. **We will need the following sent back to us by this** _____

1. **Attached PWO completed** (Note: See below)
2. **Supporting clinical notes**

→ **It is imperative that no sections are left blank. The following must be COMPLETELY filled out:**

- ✓ **Due Date**
- ✓ **Diagnosis** (Diagnosis Code, Duration of Need, and all Yes/No Questions MUST be answered)
- ✓ **Brace Size**

****** WE CANNOT ACCEPT THE FORM UNLESS IT IS COMPLETELY FILLED OUT WITH SUPPORTING CLINICAL NOTES ATTACHED ******

Our preferred method of submission is via email at: rx@mamastrut.com, but we can also receive faxes at: (424) 293-1283

If you have any questions, please call us at (844) 370-1858 and select extension 1 for assistance.

Best Regards,
Mama Strut Mama Care
PELV-ICE, LLC
www.mamastrut.com

Physician's Written Order

Total Pelvic Support System

MamaStrut™ by PELV-ICE

Due Date _____/_____ /_____ Start Date _____/_____ /_____

Patient Info

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

Address: _____ **Phone #:** _____

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

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
- ☐ O71.89 – 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)

Anwer All Questions below:

- ☐yes ☐no Did the patient have a 3rd or 4th degree vaginal tear with a previous delivery?
- ☐yes ☐no Did the patient have a breakdown of the suture, opening of skin with infection in a previous delivery?
- ☐yes ☐no Did the patient have an episiotomy with a previous delivery?
- ☐yes ☐no Did the patient have a rectal fissure repaired after delivery?
- ☐yes ☐no Did the patient have a prolonged recovery from a vaginal tear in a previous delivery?
- ☐yes ☐no Did the patient have a prior c-section with wound infection and/or wound disruption?
- ☐yes ☐no Does the patient have diastasis or hernia from a prior c-section or vaginal delivery?
- ☐yes ☐no Did the patient suffer with recurrent/persistent low back pain with this pregnancy?
- ☐yes ☐no Does the patient have a BMI over 30 with an increased wound infection risk?
- ☐yes ☐no Does the patient have severe diabetes and a history/or increased risk for wound infections, slow healing wounds?
- ☐yes ☐no Does the patient have genital prolapse?
- ☐yes ☐no Does the patient have a history of hemorrhoids?
- ☐yes ☐no Does the patient suffer from pelvic floor dysfunction or incontinence?

Insurance

Primary Insurance: _____

Policy/ID #: _____

Group #: _____

Phone #: _____

Secondary Insurance: _____

Policy/ID #: _____

Group #: _____

Phone #: _____

Doctor Info

Prescribing Physician Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Select Product & Appropriate Size

Check one & Appropriate Size

Medical Grade Mama Strut Postpartum Care System

Select Size: ☐ 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.

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 #: _____

Clinical Notes

Patient Name:

Notes: