



DEFENDER

Rx form



PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR ORDER

- Rx form
- Patient face-sheet w/patient demographics & insurance info
- Patient medical records that include primary diagnosis for Defender walker boot and supporting chart notes.

Verse Medical

Orders can be placed by: fax:

833-694-1477

phone: 929-810-2500

email: sales@versemedical.com

FROM: CLINIC / PHYSICIAN NAME/ADDRESS OR STAMP BELOW

Patient Name: _____ DOB: _____

Cell Phone: _____ Home Phone: _____

Diagnosis: _____ Right: _____ Left: _____

Notes: _____ Secondary (not required): _____



PRODUCTS SUPPLIED (CHECK WHICH APPLIES)

FOOT DEFENDER - PROTECTIVE BOOT (HCPCS - L4361)

(universal right and left)

Selection	Shoe size (USA)
<input type="checkbox"/> Small	(Men's 5-7, Women's 7-9)
<input type="checkbox"/> Medium	(Men's 7.5-9.5, Women's 9.5-11.5)
<input type="checkbox"/> Large	(Men's 10-12.5, Women's 12-14)
<input type="checkbox"/> X-Large	(Men's 13-15, Women's N/A)

COMMON DIAGNOSIS CODES (for reference):

- Osteoarthritis/DJD - M19.071(R) or M19.072 (L)
- Equinus - M21.6X1 (R) or M21.6X2 (L)
- Contracture Foot - M24.574 (R) or M24.575 (L)
- Unstable ankle - M25.371 (R) or M25.372 (L)
- Instability foot - M25.374 (R) or M25.375 (L)
- Foot drop - M21.371 (R) or M21.372 (L)

By my signature, I am prescribing the item(s) indicated for the patient named above. In my professional judgement, the item(s) is medically indicated, necessary and consistent with the current accepted standards of medical practice and treatment of this patient's physical condition. A qualified individual has performed the proper fitting, adjustment and education of the item(s) with the patient as required by law.

Physician Signature _____ NPI# _____ Date _____