# NEW YORK RECOVERY DME CORP

16 Sumner Place Brooklyn NY 11206
Phone: 212-235-5181

*Intake Written Form*

Name: _____ Gender: M / F Language: _____

Date of Birth: _____ Phone: _____ Cell: _____ Email: _____

Address: _____ City/State/Zip: _____

Primary Insurance: _____ Policy #: _____

Other Insurance: _____ Policy #: _____

Emergency Contact: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Physician Information

Physician: _____ NPI: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

Diagnosis (ICD-10 Code): Left Right Bilateral

| **Spinal** | **Foot/Ankle** | **Knee** | **Shoes/Insert** | **Hand** |
|---|---|---|---|---|
| ☐ LSO-L0637/L0650<br>☐ TLSO-L0456/L0457<br>☐ Scoliosis- L1005<br>☐ Cervical Collar-L0180 | ☐ CAM Boot L4360/L4361<br>☐ AIR Boot-L4386 L4387<br>☐ FOOT DROP AFO-L1951<br>☐ SMO-L1907, 2330, 2820<br>☐ Hinged AFO-L1970, 2820, 2275<br>☐ Solid AFO-L1960, L2350, 2232<br>☐ Secure Balance-L1940, 2820, 2330<br>☐ Arizona Brace L1940,L3230,L2820,L5000<br>☐ Night Splint – L4396 | ☐ K.O./ Post-OP-L1832/L1833<br>☐ SUSPENSION SLEEVE- L2397<br>☐ OTS OA-L1843<br>☐ OTS ACL- L1845, 2275<br>☐ Custom OA-L 1844, 2820, 2830, 2275<br>☐ Custom ACL-L1846, 2820, 2830, 2275<br>☐ KAFO custom L2036, L246X2, L2820, L2830, L2240X2, L2270<br>☐ HIP BRACE L1690 | ☐ UCBL-L3000X2<br>☐ Orthotic- L3020X2<br>☐ Ortho Shoe-L3219X2 (Men)<br>☐ Ortho Shoe-L3215X2 (Women)<br>☐ DM Shoe (Acre)-A5500X2, A5512X6 | ☐ Wrist- L3915<br>☐ Thumb- L3809<br>☐ Elbow- L3760<br>☐ Shoulder- L3960<br>**Other:**<br>☐ Lymphedema Pump – E0652 E0667 |

Signature- I certify that I have thoroughly documented the patient's medical necessity for the product(s) ordered w/in the patient's medical records and will provide all supporting documentation to Medical Finance Resources, if requested.

Physician Signature: _____ Date: _____

PLEASE FAX PRESCRIPTION TO: 718-650-6406
OR EMAIL TO: Office@nyrecoverdme.com
Note: If any corrections to information, i.e. spelling, address, etc. are needed, please correct and initial