PATIENT NAME ____________________ **DATE** ____________

DOB ________ **PHONE NUMBER** ____________________

DIAGNOSIS ____________________

I CERTIFY THAT THE ITEMS LISTED BELOW ARE MEDICALLY NECESSARY FOR THE TREATMENT OF THE PATIENT FOR THE ABOVE CONDITION

☐ Horizon™ 456 TLSO ☐ Horizon™ 637 LSO ☐ Horizon™ 631 LSO ☐ Horizon™ 627 Lumbar

DISPENSE AS WRITTEN **DO NOT SUBSTITUTE**

____________ ____________________ M.D.

UPIN# PHYSICIAN SIGNATURE

MK504A 5/14

ADVANCED MEDICAL BROKERAGE

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