CORFLEX®

Contender® Post-Op Braces

℞ Prescription Form

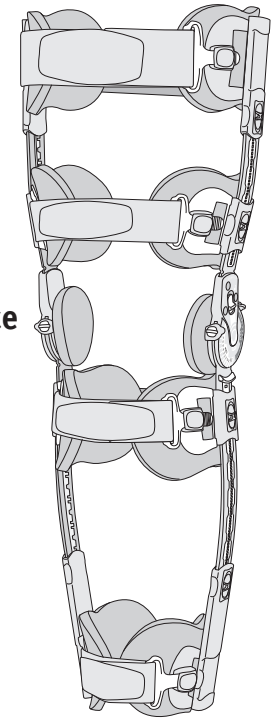
PATIENT NAME _____
DATE OF BIRTH _____
PATIENT PHONE _____
ICD-10 CODE _____
DIAGNOSIS _____
PHYSICIAN NAME _____
PHYSICIAN NPI # _____

FACILITY NAME _____
ADDRESS _____
_____
CITY _____
STATE _____ **ZIP** _____
OFFICE PHONE _____
OFFICE FAX _____

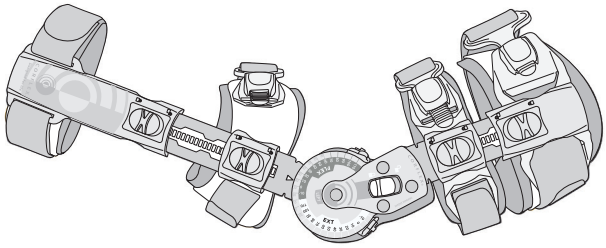
Prescribed Product

Contender Post-Op Knee Brace
L1832 (Custom Fit)/L1833 (OTS)

☐ **Lite Liner**
☐ **Full Foam Liner**



Lite Liner shown



Contender Post-Op Elbow Brace
L3760

☐ **Right**
☐ **Left**

Contender Post-Op Elbow Hand Attachment (not shown)
L3999

☐ **Right**
☐ **Left**
☐ **Neutral**
☐ **Pronation**
☐ **Supination**

ADDITIONAL COMMENTS

It is my expert opinion that the product indicated for the above-named patient is medically reasonable and necessary to facilitate management of this patient's diagnosis. Please dispense as written.

PHYSICIAN/PROVIDER SIGNATURE _____ **DATE** _____
(WITH CREDENTIALS)

Dispense as Written. No Substitutions.