

Dear Bio Back Customer:

In order to expedite the approval and shipping of your recent order for the Bio Back™ back brace, please schedule a visit with your doctor as soon as possible. Be sure to bring the **Physician Order Form** For Lumbar Orthosis for your Doctor to complete.

Upon completion of the enclosed form, you may either fax the form to:

Bio Back Marketing at 614-784-1911 or mail the completed form to:
Bio Back Marketing at 1253 Morse Rd., Columbus, OH 43229

As you know, Medicare approved the Bio-Back™ back support on April 1, 2004 for reimbursement by Medicare Part B and Private Insurance Companies under HCPCS Code LO627.

Bio-Back™'s revolutionary design is changing the entire industry, and the lives of the people who have finally found relief from back pain. It is patented in the USA and 22 other countries, and classified by the FDA as a "Non-Invasive Medical Device", receiving the FDA Medical Device Registration Number 3003955691.

We greatly appreciate your ordering the Bio-Back™ back support brace and look forward to shipping it to you as soon as the required Physician paperwork has been completed and processed under your insurance guidelines.

Please feel free to contact us directly if you have any questions at 614-264-1155.

Thank you.

JM-101-JW

Secondary Insurance Company

JM-101-JW

Name of Insurance Company

Subscriber's Name

Sex

Social Security Number

Date of Birth

Policy Effective Date: To and From

Policy Number

Group Number

Customer Service Phone Number

Claims Mailing Address:

Street

City

State

Zip Code

REFERRING PHYSICIAN:

Physician's Name

Street Address of Office

City

State

Zip Code

Information Taken By: _____ **Date:** _____

Bio-Back Support Brace

Physician Order Form For Lumbar Orthosis

Date: _____

Patient Name: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

HCPCS Number: **LO627**

Common Back Related ICD-9 Codes:

| | | | |
|--------|----------------------------------|-------|-----------------------------|
| 720.0 | Ankylosing Spondylitis | 721.3 | Osteoarthritis, generalized |
| 724.2 | Low Back Pain | 722.5 | Difficulty in Walking |
| 721.90 | Osteoarthritis of Spine | 846.0 | Spasm of Muscle |
| 724.3 | Lumbar Region | 846.1 | Abnormality of Gait |
| 739.3 | Thoracic or Lumbosacral Neuritis | 847.4 | Abnormal Posture |

ICD-9 Diagnosis Code(s): _____

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Physician's UPIN: _____ Phone: _____

Physician's Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

Statement to Permit Payment of
Medicare Benefits to Provider
Physician and Patient

Name of Beneficiary

Health Insurance Claim Number

Date

I request that payment of authorized Medicare benefits be made on my behalf to Bio Dynamics Healthcare Solutions, LLC for any services furnished me by Bio Dynamics Healthcare Solutions, LLC. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related items or services.

Signature

Date