STAR DME
Medical & Surgical Supply

Star DME Inc.
141-04 Rockaway Blvd, Suite 1F, Jamaica, NY 11436
Fax 844-438-5893 · Ph 917-300-2692
stardme.com

Back Brace (LSO)

HCPCS L0650

Standard Written Order (SWO) and documentation guide. Fax this order with the patient's most recent visit note to **844-438-5893**.

Patient Information

Name _____ **DOB** _____

Address _____

Phone _____ **Cell** _____

Primary Insurance _____ **ID#** _____

Secondary Insurance _____ **ID#** _____

Order

	CODE	ITEM	QUANTITY
☐	**L0650**	Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid anterior and posterior panels, prefabricated, off-the-shelf	**1 brace**

Length of need _____

Diagnosis / ICD-10 _____

Coverage Criteria

Check only what is documented in the chart. Medicare LCD L33790 (Spinal Orthoses). The brace must be ordered for at least one of these:

- ☐ To reduce pain by restricting mobility of the trunk
- ☐ To facilitate healing following an injury to the spine or related soft tissues
- ☐ To facilitate healing following a surgical procedure on the spine or related soft tissue
- ☐ To otherwise support weak spinal muscles and/or a deformed spine

What the Visit Note Must Show

In the treating practitioner's own words, from a recent visit:

- The diagnosis and which of the indications above the brace is ordered for
- Symptoms and how they limit daily activities (pain level, bending, lifting, standing, walking)
- Exam findings from a recent visit with the treating practitioner
- Treatments already tried when relevant (medication, physical therapy, injections)
- Why a lumbar-sacral orthosis is medically necessary for this patient

PRIOR AUTHORIZATION REQUIRED

Medicare requires prior authorization for L0650. Star DME submits the request using your notes, so please fax the most recent visit note with this order.

Practitioner

Signature _____ **Order date** _____

Printed name _____ **NPI** _____

Signature and date stamps are not acceptable. This form does not replace the practitioner's own medical record.

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Hinged Knee Brace

HCPCS L1833

Standard Written Order (SWO) and documentation guide. Fax this order with the patient's most recent visit note to **844-438-5893**.

Patient Information

Name _____ **DOB** _____

Address _____

Phone _____ **Cell** _____

Primary Insurance _____ **ID#** _____

Secondary Insurance _____ **ID#** _____

Order

	CODE	ITEM	QUANTITY
☐	**L1833**	Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the-shelf	**1 per knee**

☐ **Right** ☐ **Left** ☐ **Both** **Length of need** _____

Diagnosis / ICD-10 _____

Coverage Criteria

Check only what is documented in the chart. Medicare LCD L33318 (Knee Orthoses). The patient meets one of these:

- ☐ Recent injury to the knee or recent surgical procedure on the knee
- ☐ Ambulatory, with knee instability documented by an objective exam

What the Visit Note Must Show

In the treating practitioner's own words, from a recent visit:

- Which knee (right, left or both) and the diagnosis
- Knee exam with an objective description of joint laxity (for example varus/valgus stress test or anterior/posterior drawer test)
- That the patient is ambulatory, and how the knee limits walking, stairs or daily activities
- For a recent injury or surgery: the date and type of injury or procedure
- Note: "feels unstable" or an X-ray report alone does not document instability

FACE-TO-FACE VISIT, ORDER BEFORE DELIVERY, PRIOR AUTHORIZATION

Since October 28, 2026, Medicare requires a face-to-face visit with the treating practitioner within 6 months before this order, this signed order before delivery, and prior authorization. Please fax the visit note with this order.

Practitioner

Signature _____ **Order date** _____

Printed name _____ **NPI** _____

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Wrist Hand Orthosis

HCPCS L3916

Standard Written Order (SWO) and documentation guide. Fax this order with the patient's most recent visit note to **844-438-5893**.

Patient Information

Name _____ **DOB** _____

Address _____

Phone _____ **Cell** _____

Primary Insurance _____ **ID#** _____

Secondary Insurance _____ **ID#** _____

Order

	CODE	ITEM	QUANTITY
☐	**L3916**	Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf	**1 per side**

☐ **Right** ☐ **Left** ☐ **Both** **Length of need** _____

Diagnosis / ICD-10 _____

Coverage Criteria

Check only what is documented in the chart. Medicare braces benefit. There is no separate LCD for this item, so the record must show it is reasonable and necessary:

- ☐ Ordered to support, protect or limit motion of an injured, weak or diseased wrist and hand
- ☐ The medical record explains why this brace is needed for this patient

What the Visit Note Must Show

In the treating practitioner's own words, from a recent visit:

- The diagnosis (for example carpal tunnel syndrome, sprain, tendonitis, arthritis) and which side
- Symptoms and exam findings: pain, numbness, weakness, swelling or limited motion
- How the condition limits daily activities such as gripping, lifting or self-care
- Treatments already tried when relevant, and why the brace is needed now

FACE-TO-FACE VISIT, ORDER BEFORE DELIVERY, PRIOR AUTHORIZATION

New York is in phase 1. Since October 28, 2026, Medicare requires a face-to-face visit within 6 months before this order, this signed order before delivery, and prior authorization. Please fax the visit note with this order.

Practitioner

Signature _____ **Order date** _____

Printed name _____ **NPI** _____

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Ankle Foot Orthosis (AFO)

HCPCS L1933 / L1952

Standard Written Order (SWO) and documentation guide. Fax this order with the patient's most recent visit note to **844-438-5893**.

Patient Information

Name _____ **DOB** _____

Address _____

Phone _____ **Cell** _____

Primary Insurance _____ **ID#** _____

Secondary Insurance _____ **ID#** _____

Order

	CODE	ITEM	QUANTITY
☐	**L1933**	Ankle foot orthosis, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, off-the-shelf	**1 per side**
☐	**L1952**	Ankle foot orthosis, spiral (Institute of Rehabilitative Medicine type), plastic or other material, prefabricated, off-the-shelf	**1 per side**

☐ **Right** ☐ **Left** ☐ **Both** **Length of need** _____

Diagnosis / ICD-10 _____

Coverage Criteria

Check only what is documented in the chart. Medicare LCD L33686 (Ankle-Foot Orthoses). The patient meets all of these:

- ☐ Ambulatory (able to walk)
- ☐ Weakness or deformity of the foot and ankle that requires stabilization for medical reasons
- ☐ Has the potential to benefit functionally from the AFO

What the Visit Note Must Show

In the treating practitioner's own words, from a recent visit:

- The diagnosis and which side (for example foot drop, stroke, neuropathy, tendon dysfunction)
- Exam findings showing weakness or deformity of the foot and ankle, such as dorsiflexion strength
- That the patient is ambulatory, and how the AFO will improve walking or safety
- Why stabilization of the foot and ankle is medically necessary

FACE-TO-FACE VISIT AND ORDER BEFORE DELIVERY

Since October 28, 2026, Medicare requires a face-to-face visit with the treating practitioner within 6 months before this order, and this signed order before delivery. Please fax the visit note with this order.

Practitioner

Signature _____ **Order date** _____

Printed name _____ **NPI** _____

Signature and date stamps are not acceptable. This form does not replace the practitioner's own medical record.

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CAM Walking Boot

HCPCS L4361

Standard Written Order (SWO) and documentation guide. Fax this order with the patient's most recent visit note to **844-438-5893**.

Patient Information

Name _____ **DOB** _____

Address _____

Phone _____ **Cell** _____

Primary Insurance _____ **ID#** _____

Secondary Insurance _____ **ID#** _____

Order

	CODE	ITEM	QUANTITY
☐	**L4361**	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf	**1 per side**

☐ **Right** ☐ **Left** ☐ **Both** **Length of need** _____

Diagnosis / ICD-10 _____

Coverage Criteria

Check only what is documented in the chart. Medicare LCD L33686 (Ankle-Foot Orthoses). The patient meets all of these:

- ☐ Ambulatory (able to walk)
- ☐ Weakness or deformity of the foot and ankle that requires stabilization for medical reasons, such as a fracture, severe sprain or surgery
- ☐ Has the potential to benefit functionally from the boot

What the Visit Note Must Show

In the treating practitioner's own words, from a recent visit:

- The diagnosis and which side (for example ankle or foot fracture, severe sprain, Achilles injury, foot surgery)
- The date and type of the injury or surgery
- Exam findings, and why the foot and ankle need to be immobilized and stabilized
- That the patient is ambulatory and able to walk with the boot

Practitioner

Signature _____ **Order date** _____

Printed name _____ **NPI** _____

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Standard Written Order (SWO)

CGM · FREESTYLE LIBRE SYSTEM

INSTRUCTIONS

1. Complete all fields on this Standard Written Order (SWO).
2. Fax to DME supplier **844–438–5893** both this order and the patient's most recent **medical records** that demonstrate coverage criteria are met.

Patient Information

Name _____ **DOB** _____

Address _____

Phone _____ **Cell** _____

Primary Insurance _____ **ID#** _____

Secondary Insurance _____ **ID#** _____

Items Ordered

☐ **E2103 (FreeStyle Libre Reader)**
1 Reader/1095 Days
Length of need: Lifetime – unless specified otherwise:
_____

☐ **A4239 (FreeStyle Libre Sensor)**
1 Unit/30 Days (1 Unit = 1 month of sensors and supplies)
Length of need: Lifetime – unless specified otherwise:
_____

DIAGNOSIS

- ☐ E10.9 Type 1 diabetes mellitus without complications
- ☐ E10.65 Type 1 diabetes mellitus with hyperglycemia
- ☐ Other: _____
- ☐ E11.65 Type 2 diabetes mellitus with hyperglycemia
- ☐ E11.8 Type 2 diabetes mellitus with unspecified complications
- ☐ E11.9 Type 2 diabetes mellitus without complications
- ☐ Other: _____

CURRENT REGIMEN

- ☐ The beneficiary is insulin-treated; OR,
- ☐ The beneficiary has a history of problematic hypoglycemia with documentation of at least one of the following:
  - ☐ Recurrent (more than one) level 2 hypoglycemic events (glucose <54 mg/dL (3.0 mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; or,
  - ☐ A history of one level 3 hypoglycemic event (glucose <54 mg/dL (3.0 mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia.

Physician Information

I certify that I am the physician identified in the "Physician Information" section below and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician's Signature _____ **Name** _____

NPI # _____ **Date** _____

Signature and date stamps are not acceptable.

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Diabetic Shoes and Inserts

HCPCS A5500 / A5512 / A5513

Standard Written Order (SWO) and documentation guide. Fax this order with the patient's most recent visit note to **844-438-5893**.

Patient Information

Name _____ **DOB** _____

Address _____

Phone _____ **Cell** _____

Primary Insurance _____ **ID#** _____

Secondary Insurance _____ **ID#** _____

Order

	CODE	ITEM	QUANTITY
☐	**A5500**	Diabetic depth-inlay shoe, off-the-shelf, fitted (per shoe)	**1 pair per calendar year**
☐	**A5512**	Multiple-density insert, direct formed, heat molded to the foot (each)	**up to 3 pairs per year**
☐	**A5513**	Multiple-density insert, custom molded from a model of the patient's foot (each)	**up to 3 pairs per year**

Length of need _____

Diagnosis / ICD-10 _____

Coverage Criteria

Check only what is documented in the chart. Medicare LCD L33369. The patient has diabetes and at least one of:

- ☐ Previous amputation of the other foot, or part of either foot
- ☐ History of previous foot ulceration of either foot
- ☐ History of pre-ulcerative calluses of either foot
- ☐ Peripheral neuropathy with evidence of callus formation of either foot
- ☐ Foot deformity of either foot
- ☐ Poor circulation in either foot

What the Visit Note Must Show

In the treating practitioner's own words, from a recent visit:

- Foot doctor: an in-person foot exam documenting which condition above the patient has
- Primary care physician (MD or DO managing the diabetes): an in-person visit within 6 months before delivery documenting diabetes management
- The physician's signed certification statement, dated on or after that visit and within 3 months before delivery

HOW THE ORDER WORKS

1. The patient sees the foot doctor (podiatrist) for a foot exam. The foot doctor completes this prescription and a visit note.
2. Fax this prescription and the visit note to Star DME at **844-438-5893**.
3. Star DME sends the primary care physician the therapeutic shoe certification and the foot exam acknowledgement to sign.

Prescribing Practitioner (Foot Doctor)

Signature _____ **Order date** _____

Printed name _____ **NPI** _____

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Incontinence Supplies

NY MEDICAID · FISCAL ORDER

Written order for a 30-day supply. Fax this order with the patient's most recent visit note to **844-438-5893**.

Patient Information

Name _____ **DOB** _____

Address _____

Phone _____ **Cell** _____

Primary Insurance _____ **ID#** _____

Secondary Insurance _____ **ID#** _____

Medicaid CIN _____ **Age** _____ **Weight** _____ lbs **Waist** _____ in **Hip** _____ in

Diagnosis

a specific ICD-10 code is required; check all that apply

URINARY

- ☐ **N39.3** Stress incontinence
- ☐ **N39.41** Urge incontinence
- ☐ **N39.45** Continuous leakage
- ☐ **N39.46** Mixed incontinence
- ☐ **N39.490** Overflow incontinence
- ☐ **R39.81** Functional incontinence

FECAL

- ☐ **R15.9** Full incontinence of feces
- ☐ **R15.0** Incomplete defecation
- ☐ **R15.1** Fecal smearing
- ☐ **R15.2** Fecal urgency

Other ICD-10 _____ **Cause of incontinence** _____

Supplies Ordered

per 30 days

ITEM	CHANGES PER DAY	QTY / 30 DAYS
☐ **Disposable briefs / pull-ons** — one size: ADULT ☐ S T4521 ☐ M T4522 ☐ L T4523 ☐ XL T4524 ☐ Above XL T4543	_____	_____ max 250 combined with liners
☐ **T4535** Disposable liners / shields / guards	_____	_____
☐ **A4554** Disposable underpads (Chux), all sizes **Covered with:** N39.3 (female), N39.41, N39.42, N39.45, N39.46, R39.81, R15.0, R15.2, R15.9 **Not covered with:** N39.3 (male), N39.43, N39.44, N39.490, R15.1	_____	_____ max 150

Start date _____ **Length of need** ☐ **12 months** ☐ **Lifetime (99)** **Refills** _____

Documented in the Chart

Check only what the practitioner's own visit note shows. The record must support the type and quantity ordered.

- ☐ Type of incontinence and its medical cause (e.g. stroke, SCI, dementia)
- ☐ Changes needed per day and why, supporting the quantity
- ☐ Current weight, waist and hip, supporting the size
- ☐ Underpads: why bed, chair or wheelchair protection is needed

Above 250 briefs/liners or 150 underpads needs prior approval with documentation of a condition causing increased urine or stool output.

Practitioner

Signature _____ **Date** _____

Printed name _____ **NPI** _____ **Phone / Fax** _____

Signature and date stamps are not acceptable. This form does not replace the practitioner's own medical record.