Prescription & Letter of Medical Necessity For Knee Orthosis

Patient Name: _____ Patient DOB: _____
Medicare #: _____ Patient Phone: _____
Treating Physician: _____
Physician Address: _____
City: _____ State: _____ Zip: _____
Physician Phone: _____ Physician Fax: _____

Instructions: The above named patient has request that you fill out this order form. Please complete the entire form and fax to the number below. Per Medicare guidelines, we are required to obtain **progress notes** along with this **signed RX** and **qualifying diagnosis code(s)** for product sought by your patient. Please make sure the supporting documentation is faxed to validate **medical necessity** in order to facilitate your patients' request. Unfortunately, without these necessary documents we will not be able to supply the product requested by your patient.

Item(s) to be ordered:

L1832 – Thermoskin Hinged Knee Range of Motion

___ LEFT ___ RIGHT ___ B/L

Please check all diagnosis that pertains to this patient's condition:

___ Failed total knee anthroplasty (T84.119A/T84.129A/T84.199A/T84.498A/T84.50XA/)
___ Rheumatoid Arthritis (M06.9 M12.00)
___ Osteoarthritis (M17.10 M17.5 M17.9)
___ Meniscal cartilage derangement (M23.205 M23.009)
___ Chonodromalacia of patella (M22.40)
___ Knee ligamentous disruption (M23.50 M23.90)
___ Pathologic fracture of femur (M84.453A)
___ Pathologic fracture of tibia or fibula (M84.469A)
___ Dislocation of knee (S83.219A S83.249A- S83.196A S83.009A)
___ Asceptic necrosis of tibia or fibula (M87.08)
___ Stress fracture of tibia or fibula (M84.369A)
___ Rupture of tendon, nontraumatic-quadriceps tendon (M66.259)
___ Congenital deformity of knee (M68.2 Q74.1)
___ Fracture of femur – lower end (S72.409A – S72.499B/S72.499C)
___ Fracture of patella (S82.009A)
___ Fracture of tibia and/or fibula – upper end (S82.109A – S82.161A S82.811A S82.162A S82.812A)
___ Sprains and strains of knee (S83.429A S83.509A
___ Chronic knee joint pain (M25.561-M25.562)

This patient is being treated under a comprehensive plan of care for arthritis/pain. I, the undersigned, certify that the above prescribed is medically necessary for the patients overall well being. In my opinion, the following orthotic/arthritic relief products are both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be made available upon request.

Physicians Signature: _____ **NPI #:** _____ Date: _____