Physician Order, Prescription, and Certificate of Medical Necessity for Knee Orthosis with Adjustable Knee Joints (L1832 or L1845)

Date:_______________

Patient Name

Address City State Zip Code

Medicare #______________________ Date of Birth ___________________ Male ☐ Female ☐

(MM / DD / YYYY)

Dr. Information

Treating Physician NPI #

Address City State Zip Code

Office Phone Office Fax

I confirmed that I have seen this beneficiary within the last six (6) months to evaluate their diagnosis and have identified the reason for using this support. Please ensure this reason is denoted in your beneficiary's medical records. Please dispense as written.

☑
- ☐ Osteoarthritis
- ☐ Knee Instability
- ☐ Lateral or Medial Compartmental Arthritis
- ☐ Other – Please Specify: _________________________________

ICD-9 Code:

SAMPLE

☑
- ☐ Rheumatiod Arthritis (714.0)
- ☐ Osteoarthritis – Primary Lower Leg (715.16)
- ☐ Osteoarthritis – Secondary Lower Leg (715.26)
- ☐ Osteoarthritis – Involving Lower Leg (715.96)
- ☐ Osteoarthritis – Not Specified Lower Leg (715.36)
- ☐ Other – Please Specify: _____________________

☑ **Duration: Patient has had this condition for ___ month's ___ years. (Chronic = 3 months or more)**

☑ **Estimated Length of Need (# of Months)_____ 1-99 (99 = Lifetime)**

☑ **Specific Knee Needed for Treatment** ☐ **Left** ☐ **Right** ☐ **Both**

Our evaluation of the above patient has determined that providing the following knee pain management Knee Orthosis product will benefit this patient. Check the appropriate box below for **Quantity 1 Knee Brace.**

☑ ☐ L1832 Knee Orthosis Brace Adjustable Knee Joints. Knee orthoisis, adjustable knee joints (unicentric or polycentric, positional orthosis, rigid support, prefabricated, includes fitting and adjustment.

☐ L1845 Knee Orthosis Brace Adjustable Flexion & Extension. Knee orthoisis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotational control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment.

*

(Physician Signature M.D. or D.O.) **Date**

- ***If a CRNP or PA signs Rx, to meet Insurance Guidelines an M.D. or D.O. wet ink or stamped Signature must accompany signature.***