**PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FOR DELUXE KNEE ORTHOSIS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Please Send RX Form & Pertinent Chart Notes** | | | **Fax No: (305) 390 3669** |
|  |  | **PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS** | | |
|  |  |  |  |  |
| Date: | ${order\_Date} |  |  |  |
| First: | ${fname} | Last: ${lname} | Physician Name: ${phy\_name} | |
| DOB: |  | ${dob} | NPI: | ${phy\_npi} |
| Address: |  | ${address} | Address: | ${phy\_address} |
| City: |  | ${city} | City: | ${phy\_city} |
| State: |  | ${state} | State: | ${phy\_state} |
| Postal Code: |  | ${postal\_Code} | Postal code:  ${phy\_postal\_code} | |
| Patient Phone Number: ${phone\_num} | | Policy #: ${policy\_num} | Phone Number: ${phy\_phone\_num} | |
| Primary Ins: | ${primary\_ins} | Fax Number: ${phy\_fax} | |
| Private Ins: | ${private\_ins} | Policy #: - |  |  |
| Height: {height} | Weight: ${weight} |  |  |  |

*This patient is being treated under a comprehensive plan of care for knee pain.*

*I, the undersigned; certify that the prescribed orthosis is medically necessary for the patient’s overall well-being. This patient has suffered an injury or undergone knee surgery. In my opinion, the following knee orthosis products are both reasonable and necessary in reference to treatment of the patient’s condition and/or rehabilitation. My patient has been in my care regarding the diagnosis below. This is the treatment I see fit for this patient at this time. I certify that this information is true and correct.*

**DIAGNOSIS:** Provider can simply cut off the diagnosis which they don’t find appropriate

Rheumatoid Arthritis without rheumatoid factor, right knee (M06.061)

Rheumatoid Arthritis without rheumatoid factor, left knee (M06.062)

Pain in right knee (M25.561)

Pain in left knee (M25.562)

Bilateral Primary Osteoarthritis (M17.0)

Chronic instability of knee, right knee (M23.51)

Chronic instability of knee, left knee (M23.52)

Other /Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **AFFECTED AREA:** | Left Knee **** | Right Knee **** |
| KNEE: |

**Our evaluation of the above patient has determined that providing the following knee orthosis product will benefit this patient**

**DISPENSE:**

**L1852**: KNEE ORTHOSIS (KO), DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF

**L2397**: ADDITION TO LOWER EXTREMITY ORTHOSIS, SUSPENSION SLEEVE

Length of need is 99 months unless otherwise specified: \_\_\_\_\_ 6 - 99 (99= LIFETIME)

${phy\_signature:100:80} ${phy\_signed\_date}

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Name:** ${phy\_name} **NPI:** ${phy\_npi}