CONFIDENTIAL Fax

FROM:

BRYAN K HODGE, DO
709 N Justice St Ste B, Hendersonville, NC 28791-3455
Phone: (828) 696-1234
Fax: (833) 963-0843

TO:

Fax: (318) 413-3018

Delta Medical

"Our Mutual Patient"

-Urgent Request-

Delta Medical

PHONE: (508) 492-6170, FAX: (318) 413-3018 // (540) 380-0089

To: DR. BRYAN HODGE, DO

Fax: 8285135041 Date: 05-06-2025

Patient: JOE CAVE D.O.B. 06-30-1936

Dear Physician

Our mutual patient is requesting a signed prescription form, please review, sign and send it back as soon as possible, kindly add the last 6 months of visit chartnotes in order to support the necessity of the DME.

As soon as possible FAX: (318) 413-3018
(540) 380-0089

Confidential Protected Heath Information Enclosed

PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FOR DELUXE KNEE ORTHOSIS

Please Send RX Form & Pertinent Chart Notes **FAX NO: (318)413-3018**

PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS

Date: 05-05-2025 **First: JOE** **Last: CAVE** **DOB: 06-30-1936** Address: 36 Yale Ln City: Brevard State: NC Postal Code: 28712 Patient Phone Number: 8288846011 Primary Insurance: Medicare Policy#: 8R39Q81UU37 Height: 6'2 ft Weight: 230 lbs	**Physician Name: DR. BRYAN HODGE, DO** **NPI: 1457545279** Address: 709 N JUSTICE ST, SUITE B City: HENDERSONVILLE State: NC Postal Code: 28791 Phone Number: 8286924289 Fax Number: 8285135041

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 assisting in restoring loss of motion of the joints and following immobilization. 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)
Unilateral Primary Osteoarthritis, Right knee (M17.11)
Unilateral Primary Osteoarthritis, left knee (M17.12)
Bilateral Primary Osteoarthritis of knee (M17.0)
Chronic instability of knee, right knee (M23.51)
Chronic instability of knee, left knee (M23.52)
Other /Explain: _____

Scan for recording

AFFECTED AREA:
KNEE: Left Knee ☒ Right Knee ☐

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

DISPENSE:

L1833: Knee orthosis (KO), adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf.

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

Physician Signature: Electronically signed by BRYAN K HODGE, DO on 05/06/2025 at 05:12:59 am **Date Signed:** 5/6/25

Physician Name: **NPI:**