Prescription / Letter of Medical Necessity

Advanced Physical Therapy of Central Florida, Inc.

Phone 352-693-3378 • **Fax 888-758-9645**

Patient Name Peter Jurski SSN 153-82-4243 DOB 08/09/1981

Address 22095 NE 130TH COURT RD ,FORT MCCOY,9,321324216 Phone (352) 546-5336

Date of Surgery *If applicable* _____ Date of Injury *If applicable* _____

Clinic Location SE Lake Weir Avenue in Ocala Physical Therapist _____

ORTHOPEDIC BRACING

☑ **Custom Knee L1846**

Reason for custom vs. off the shelf brace:

- ☑ Disproportionate size of thigh and calf
- ☐ Minimal muscle mass upon which to suspend an orthosis
- ☐ A typical thigh and calf dimensions due to obesity (BMI greater than or equal to 30)
- ☐ Intimate fit is required for ligament protection or off-loading indication

☐ **Soft OA Knee Offloader L1843**

☐ **Ligament Knee Brace L1845**

☐ **Rigid OA Knee Offloader L1845**

☐ **Lumbosacral Orthosis L0637**

☐ **Kyphosis Corrective Orthosis L0456**

OTHER

☐ _____ ☐ _____

☐ _____ ☐ _____

MEDICAL NECESSITY / LENGTH OF NEED

☒ **Purchase / Lifetime** ☐ **1-3 Months** ☐ **3-6 Months** ☐ **Other** _____

ICD-10 CODES G57.01 ◉ Right ○ Left ○ Do Not Substitute

Previous Treatment(s)/Medications:

- ☐ Prior Surgery
- ☐ NSAIDS/Pain Medications
- ☑ Injections
- ☐ Physical Therapy

Physician Name _____ NPI _____ Phone _____

Physician Signature _____ Date _____

I certify the above prescribed equipment is medically indicated and supports accepted standards of medical practice for this patient's condition

PLEASE RETURN THIS FORM BY FAX TO 888-758-9645