Prescription / Letter of Medical Necessity

Phone 352-693-3378 • Fax 888-758-9645

Patient Name _____ SSN _____ DOB _____

Address _____ Phone _____

Date of Surgery (If applicable) _____ Date of Injury If applicable _____

Clinic Location _____ Physical Therapist _____

ORTHOPEDIC BRACING

- ☐ **Custom Knee L1846**

  Reason for custom vs. off the shelf brace:

  - ☐ Disproportionate size of thigh and calf
  - ☐ Atypical thigh and calf dimensions due to obesity (BMI greater than or equal to 30)
  - ☐ Minimal muscle mass upon which to suspend an orthosis
  - ☐ 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 _____ Primary ICD-9 Code _____ Secondary ICD-10 Code ☐ Right ☐ Left ☐ Do Not Substitute

Previous Treatment (s)/Medications: ☐ Prior Surgery ☐ NSAIDS/Pain Medications ☐ Physical Therapy ☐ Injections

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