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 Injur applicable	y If				
Clinic Location	Physical Therapist					
ORTHOPEDIC BRACII	NG					
☐ Custom Knee L1846						
Reason for custom vs. off the shel	f brace:					
☐ Disproportionate size of thigh a	and calf					
 Atypical thigh and calf dimensio 	ns due to obesity (BMI grea	ter than or equal to 30)				
☐ Minimal muscle mass upon whic	th to suspend an orthosis					
☐ Intimate fit is required for ligam	ent protection or off-loading	g 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 Prima	ry ICD-9 Code	Secondary ICD-:	10 Code	☐ Right ☐ Lef	t ☐ Do Not Substitute
Previous Treatme (s)/Medications:	ent 🗌 Prior Su	rgery	DS/Pain ons	☐ 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