Advanced PHYSICAL THERAPY OF CENTRAL FLORIDA, INC.

Prescription / Letter of Medical Necessity

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

Patient Name anirban banarjee SSN _____ DOB 04/24/2070

Address gfgy ,hgjhj,1,7686788 Phone _____

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

Clinic Location _____ Physical Therapist user1

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 M00.062
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