Effective Date: {{date}}\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Patient’s Information**  Name: {{name}}  Address: {{address}}  Phone: {{phone}}  DOB: {{dob}}  Primary Ins: {{insurance}}  Policy #: {{medicare}} | **Physician Information**  Physician Name: {{pcp\_name}}  Address: {{pcp\_address}}  Phone Number: {{pcp\_phone}}  Fax Number: {{pcp\_fax}}  NPI: {{pcp\_npi}} |

|  |  |
| --- | --- |
| DEVICE ICD-10 DIAGNOSIS CODE | |
| Knee Brace | HCPCS: L1852 - L1843 RT LT BILATERAL  ……. |
| **M17.2** Bilateral Post-Trauma-Right Knee  **M17.11** unilateral 1. Osteoart-Right Knee  **M17.31** Unilateral Post-Trauma-Right Knee  **M17.12** Unilateral 1. Osteoart-Left Knee | **M17.32** Bilateral Post-Trauma-Right Knee  **M17.9** Bilateral Post-Trauma-Right Knee  **M22.41/M22.42** Bilateral Post-Trauma-Right Knee  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Reason for Brace:**  Increase ROM Avoidance of Surgery Avoidance of Surgery  Decrease ROM Reduce Pain by Reducing Mobility Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **LENGTH OF NEED:** This order is good for a lifetime unless otherwise indicated by the Physician: \_\_\_\_\_\_\_\_\_\_ | |
| *By my signature below, I confirm that the patient has the medical condition(s) listed above and is being treated by me. The above information is true, accurate and complete to the best of my knowledge. I certify that the items/services listed above are medically necessary to treat this patient’s condition and accurately reflect the treatment regimen I have prescribed. My medical records for this patient substantiate the prescribed treatment plan. I certify that my patient and/or caregiver are capable of using these products safely and effectively. Per Medicare, Medicaid and other insurance requirements, I will maintain a copy of this order in the patient’s medical record. I agree to provide copies of all supporting medical records substantiating the medical necessity for the products ordered as requested for insurance review/audit purposes.* | |
| Date: {{date}}\_\_\_\_\_\_\_\_ Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Print Name: {{pcp\_name}} | |
| Please sign and send back: | Thank you for your business! |