

CMN for Knee Orthosis
α L1832 ROM Knee Brace

Patient's Name: _____ HIC#: _____
 Address: _____ DOB: _____

 _____ Insurance Name: _____
 _____ Insurance Phone: _____
 Phone: _____

Need: RT _____ Size: _____ in // LT _____ Size: _____ in // Both _____

Instruction: The above named patient has requested that you fill out this order form. Our evaluation of the above patient has determined that providing the following arthritic pain relief will benefit this patient. **Please Complete ENTIRE form and FAX.** Please enter the appropriate notes in the patient's chart.

This patient has one or more of the following:

- Arthritis, Rheumatoid (714.0, 714.1, 714.2, 714.3)
- Congenital Deformity of Knee (755.64)
- Osteoarthritis (715.16, 715.26, 715.36, 715.96)
- Dislocation of Knee (836.0 – 836.69)
- Chondromalacia of Patella (717.7)
- Stress Fracture of Tibia of Fibula (733.93)
- Knee Ligamentous Disruption (717.81 – 717.9)
- Rupture of Tendon, No traumatic – Quadriceps Tendon (727.65)
- Meniscal Cartilage Derangement (717.0, 717.5)

This patient is being treated under a comprehensive plan of care for **Arthritis/Pain**. I, the undersigned certify that the above prescribed is medically necessary for the patient's overall well being. In my opinion, the following arthritic relief products are both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation.

Physician's Signature: _____ Date signed: ____/____/____

Physician Name: _____ NPI: _____

Address: _____

Physician Phone: _____ Fax: _____