

CMN for OA Knee Brace L1845

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

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

RT Knee

LT Knee

Size A: measured 4.5" from the middle of patella upwards then around thigh: _____ inches _____ inches
 Size B: measured 4" from the middle of patella downwards then around calf: _____ inches _____ inches

INSTRUCTIONS: THE ABOVE NAMED PATIENT HAS REQUESTED THAT YOU FILL OUT THIS ORDER FORM. OUR EVALUATION OF THE ABOVE PATIENT INDICATES THAT PROVIDING R.O.M. IMMOBILIZATION WILL BENEFIT THIS PATIENT. PLEASE COMPLETE ENTIRE FORM AND FAX TO THE NUMBER LOCATED AT THE BOTOM OF THE FORM. PLEASE ENTER THE APPROPRIATE NOTES IN THE PATIENT'S CHART.

Rx: L1845 – OrthoPro Rehabilitative Osteo-Arthritis (OA) Knee Brace
 LEFT RIGHT B/L VALGUS Deformity VARUS Deformity

The following notations must be on file and retrievable upon request for a L1845 prescription:
Knee instability must be documented by examination of the patient, accompanied by objective description of joint laxity (e.g., varus/valgus instability, positive anterior/posterior Drawer Test.)

Please indicate all diagnoses that pertain to this patient's condition.

- Arthritis, Rheumatoid (714.0, 714.1, 714.2, 714.3)
- Knee Replacement (V43.65)
- 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 or Fibula (733.93)
- Knee Ligamentous Disruption (717.81 – 717.9)
- Rupture of Tendon, Nontraumatic – 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 patients' 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: _____