

Knee Orthosis with Adjustable Knee Joints Prescription Form

Step 1

Patient ID#: _____ Effective Date: _____

Patient Name: Mr/Ms _____ SS#: _____

Address: _____ City: _____, _____ Zip: _____

Phone: _____ Birthday: _____

Primary: _____ Secondary: _____

Policy #: _____ Policy #: _____

ICD-10 Diagnosis Code:

- Rheumatoid Arthritis-Unspecified...M06.9
 Osteoarthritis-Primary Lower Leg ...M17.10
 Other (Please specify) _____
- Osteoarthritis of knee-Unspecified...M17.9
 Osteoarthritis – Secondary Lower Leg...M17.5

Patient Sizing, Knee Specifications and Item Description

Please choose the size based on thigh circumference at 6" above Mid-Patella:

- | SIZE | THIGH CIRCUMFERENCE |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> X-Small | -----13" to 15.5" or 33cm to 39cm |
| <input type="checkbox"/> Small | -----15.5" to 18.5" or 39 cm to 47cm |
| <input type="checkbox"/> Medium | -----18.5" to 21" or 47cm to 53cm |
| <input type="checkbox"/> Large | -----21" to 23.5" or 53cm to 60cm |
| <input type="checkbox"/> X-Large | -----23.5" to 26.5" or 60cm to 67cm |
| <input type="checkbox"/> 2X-Large | -----26.5" to 29.5" or 67cm to 75cm |
| <input type="checkbox"/> 3X-Large | -----29.5" to 32" or 75cm to 82.5cm |



Item Description & HCPCS Code:
Knee Orthosis Brace – L1832
Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, includes adjustable knee joints

Step 2

Please specify Knee for Treatment:

- Right - Left - Both

REASON FOR MEDICAL NECESSITY AND LENGTH OF NEED:

MEDICARE REQUIRES A REASON(S) FOR A KNEE ORTHOSIS WITH ADJUSTABLE KNEE JOINTS. I confirmed that I have seen this patient within the last six (6) months to evaluate their above mentioned diagnosis, have reflected need in their most recent medical chart, have identified the reason(s) for using this orthosis below:

- OSTEOARTHRITIS LATERAL or MEDIAL COMPARTMENTAL ARTHRITIS
 KNEE INSTABILITY OTHER: _____

LENGTH OF NEED IS **99 MONTHS** (unless specified): _____ months

Step 3

Print Physician's Name: _____ Ph #: _____

Physician Signature: _____ Date: _____

NPI: _____ DEA# _____ City: _____, ST: _____

By signing above, I agree to obtain the original, signed copy of this document in my medical records. My medical records and recent charts substantiate I am treating this patient under a comprehensive care plan for the above mentioned diagnosis and the patient is able to use this item herein ordered to manage his/her condition. This order accurately reflects the patient's documented diagnosis, condition, prescribed treatment and testing regimens.