CMN for Osteo-Arthritis or Knee Replacement L1845 Knee Brace

Patient Name: _____ Patient DOB: _____

Medicare # _____ Patient Phone: _____

Treating Physician: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Physician Phone: _____ Physician Fax: _____

INSTRUCTIONS: The above named patient has requested that you fill out this order form. Please complete *entire* form and fax to the number below. Per Medicare guidelines we are required to obtain **progress notes** along with this **signed RX** and **qualifying diagnosis code(s)** for product sought by your patient. Please make sure the supporting documentation is faxed to validate **medical necessity** in order to facilitate your patients' request. Unfortunately, without these necessary documents we will not be able to supply the product requested by your patient.

Item(s) to be ordered:
L1845 – Rehabilitative Osteo-Arthritis (OA) Knee Brace
☐ **LEFT** ☐ **RIGHT** ☐ **B/L**

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 (M06.9)**
- ☐ **Knee Replacement (Z47.1, Z96.651)**
- ☐ **Congenital Deformity of Knee (Q68.2)**
- ☐ **Osteoarthritis (M17.9)**
- ☐ **Dislocation of Knee (S83.006A)**
- ☐ **Chondromalacia of Patella (M22.40)**
- ☐ **Stress Fracture of Tibia or Fibula (M84.364A)**
- ☐ **Knee Ligamentous Disruption/Chronic instability of knee, unspecified knee (M23.50)**
- ☐ **Rupture of Tendon, Nontraumatic – Quadriceps Tendon (S76.1)**
- ☐ **Meniscal Cartilage Derangement (M23.239-M23.305)**

☐ **Other:** _____

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 wellbeing. 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. I certify that the patient's medical records reflect the need for the item ordered and will be made available upon request.

Physicians Signature: _____ **NPI#** _____ **Date:** _____

Please FAX this order to: 704-821-7777

Questions Call: Mobility & More 704-821-7777

REF ID