800.838.3560
866.598.3366

Eden MEDICAL SUPPLY

KNEE BRACE DETAILED WRITTEN ORDER

Patient Information

Name:
Date of Birth:
Phone Number:
Address:

Insurance ID:
Insurance Name:
Gender:

Physician Information

Name:
NPI:
Address:

Phone:
Fax:

Email:

- **Equipment to Prescribe**
  - ☐ **L1851** – KNEE ORTHOSIS, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf
  - ☐ **L1833** – KNEE ORTHOSIS, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the-shelf

② **Diagnosis**

Diagnosis Code(s): _____

③ **Which side requires a knee brace?**

☐ Both ☐ Left ☐ Right

④ **What is the medical reason for the knee brace(s)?**

☐ Recent injury or surgical procedure
☐ Patient is ambulatory and has knee instability with joint laxity documented

⑤ **Please send medical records to support medical necessity of the knee brace.**

I certify that I am the physician identified in the above section and I certify that information contained in this document reflects the patient's condition and is accurate to the best of my knowledge.

⑥ **Date**: _____ ⑦ **Physician Signature**: _____