800.838.3560
866.292.6645

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:

① 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

Statement of Medical Necessity (Items 2-7 REQUIRED**)**

② Diagnosis

☐ M25.569 ☐ M25.561 ☐ M25.562
☐ M17.9 ☐ M17.0 ☐ **Other:** _____

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**: _____