The DiABETiC Shoppe
1068 Factory Drive ~ Charleston, MS 38921
Toll-Free Phone: 1-888-571-3533 ~ Toll-Free Fax: 1-800-520-8117

Accredited by JCAHO

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 #:_____

Insulin Treated? Yes _ No _ **ICD-10 Diagnosis Code:**

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

Patient Sizing, Knee Specifications and Item Description

Step 2

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

	SIZE	THIGH CIRCUMFERENCE
❑	X-Small	13" to 15.5" or 33cm to 39cm
❑	Small	15.5" to 18.5" or 39 cm to 47cm
❑	Medium	18.5" to 21" or 47cm to 53cm
❑	Large	21" to 23.5" or 53cm to 60cm
❑	X-Large	23.5" to 26.5" or 60cm to 67cm
❑	2X-Large	26.5" to 29.5" or 67cm to 75cm
❑	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

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: _____

LENTH 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 plant 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.