CMN FOR KNEE ORTHOSIS

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:
L1832 – Thermoskin Hinged Knee Range of Motion

☐ **Left** ☐ **Right** ☐ **B/L**

Please check all diagnosis that pertains to this patient's condition:

- ☐ Rheumatoid Arthritis (714.0-714.4)
- ☐ Osteoarthritis (715.16, 715.26, 715.36, 715.96)
- ☐ Meniscal cartilage derangement (717.0-717.5)
- ☐ Chondromalacia of patella (717.7)
- ☐ Knee liagmentous disruption (717.81-717.9)
- ☐ Pathologic fracture of femur (733.15)
- ☐ Pathologic fracture of tibia or fibula (733.16)
- ☐ Asceptic necrosis of tibia or fibula (733.49)
- ☐ Stress fracture of tibia or fibula (733.93)
- ☐ Rupture of tendon, nontraumatic-quadriceps tendon (727.65)
- ☐ Congenital deformity of Knee (755.64)
- ☐ Fracture of femur - lower end (821.0-821.39)
- ☐ Fracture of patella (822.0, 822.1)
- ☐ Fracture of tibia and/or fibula - upper end (823.00-823.42)
- ☐ Dislocation of Knee (836.0-836.69)
- ☐ Sprains and strains of knee (844.0-844.2, 844.8)
- ☐ Failed total knee anthroplasty (996.40-996.49, 996.66, 996.77, V43.65)

OR:

The patient is ambulatory and has knee instability due to a condition specified in one of the following diagnosis:

- ☐ Multiple sclerosis (340)
- ☐ Hemiplegia, unspecified (342.90)
- ☐ Paraplegia of both lower limbs (344.1)
- ☐ Infantile cerebral palsy, unspecified (343.9)
- ☐ Mononeuritis of lower limb, unspecified (355.0, 355.2)

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 well being. In my opinion, the following orthotic/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 310.330-7635 ****

Confidence First Medical Supplies
316 E Manchester Blvd Inglewood, CA 90301
P:(310) 330-7636 F:(310) 330-7635