DWO for Knee Supports/Bracing

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622

DATE OF ORDER:_____

DATE OF LAST FACE TO FACE:_____

PATIENT INFORMATION

First Name_____ **Last Name**_____

Address_____ **City**_____ **State**_____ **Zip**_____ **Phone**_____

Date of Birth_____ **Emergency Contact**_____ **Emergency Contact Phone**_____

REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name_____ **Therapist Name** _____

Clinic Address_____ **City**_____ **State**_____ **Zip**_____

Phone_____ **Fax**_____**Therapist Email**_____

PRODUCT PRESCRIBED

☐ L1852 Pre-Fab Knee Orthosis, Double Upright with adjustable flexion and extension ☐ Left ☐ Right ☐ Left AND Right
Knee orthosis (ko), double 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.

☐ L1851 Pre-Fab Knee Orthosis, Single Upright with adjustable flexion and extension ☐ Left ☐ Right ☐ Left AND Right
Knee orthosis (ko), 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 Pre-Fabricated Knee Orthosis with adjustable knee joints ☐ Left ☐ Right ☐ Left AND Right
Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf

☐ Other Knee Brace _____

DIAGNOSIS

☐ **Primary ICD10 Numeric Code:**_____ ☐ **Secondary ICD10 Numeric Code:**_____

ANSWER ALL THAT APPLY

☐ Yes ☐ No	Has the patient had a recent injury to the knee(s), or a recent surgical procedure on the knee(s)?
☐ Yes ☐ No	Has the patient been evaluated by you for the use of a knee orthosis?
☐ Yes ☐ No	Are there physician notes that document the patient's knee instability?
☐ Yes ☐ No	If ordering an L1833 or L1852 knee orthosis, are there physician notes that include an objective description of joint laxity e.g., varus/valgus instability, anterior/posterior drawer test)?
Please provide the date the medical evaluation took place: _____	
NOTE: Medicare requires that the ordering physician's chart notes supporting the above for code L1833 and L1852, document knee instability by examination of the beneficiary and objective description of joint laxity (e.g., varus/valgus instability, positive anterior/posterior Drawer test).	

PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried or considered and ruled out.

Physician Name_____ **NPI#**_____ **Phone**_____ **Fax**_____

Physician Address_____ **City**_____ **State**_____ **Zip**_____

Physician Signature_____ **Date Signed**_____