

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Member ID: \_\_\_\_\_

### 1. Choose Primary Indication (Required)

**LEFT**

M17.12 Left knee **osteoarthritis**

M22.2X2 **Patellofemoral disorder**, left knee

M22.42 **Chondromalacia patella**, left

**RIGHT**

M17.11 Right knee **osteoarthritis**

M22.2X1 **Patellofemoral disorder**, right knee

M22.41 **Chondromalacia patella**, right

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M17.0 **Bilateral** primary osteoarthritis of knee

**OTHER:** \_\_\_\_\_

### 2. Choose Secondary Indication (Required)

M23.52 **Left** knee instability

M23.51 **Right** knee instability

**NOTE: Primary + Secondary indication and custom brace justification must be noted in chart/notes. Knee instability may be justified by objective description of joint laxity shown by varus/valgus instability test, anterior/ posterior DRAWER test, or Lachman test.**

Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### 3. I am ordering a...

**Custom Knee Brace L1846**

I certify that I am ordering a CUSTOM Ascender knee orthosis, L1846 because an OTS brace has not been effective in treating their symptoms.

**Upon my exam the patient has one of the following: (check one)**

A deformity of the leg or knee

The leg is too small to fit an off the shelf orthosis

The leg is too large to fit an off the shelf orthosis

Minimal muscle mass upon which to suspend orthosis

**OTS (Off-the-Shelf) Knee Brace L1845 or L1852**

I certify that I am ordering an OTS Ascender knee orthosis.

**Measurements:**

Thigh \_\_\_\_\_ in

Knee \_\_\_\_\_ in

Calf \_\_\_\_\_ in

**NOTE: The circumference measurements of the thigh and calf are to be taken 6 inches above and below the knee center. Reference sizing chart on next page to ensure an OTS brace is the proper selection.**

Prognosis: \_\_\_\_\_  
 Duration: \_\_\_\_\_  
 Expected Therapeutic Effect: \_\_\_\_\_

**\*NO SUBSTITUTION OF THIS DEVICE ALLOWED\***  
\*AS THERE IS NO CLINICALLY EQUIVALENT

Ordering Physician (PRINT): \_\_\_\_\_  
 Ordering Physician (Signature/No Stamp): \_\_\_\_\_  
 \_\_\_\_\_  
 Date: \_\_\_\_\_ NPI Number: \_\_\_\_\_

Size	Thigh	Knee Center	Calf	Caliper*
<b>XS (x=1)</b>	13.0"-14.5"	9.0"-11.0"	9.0"-11.0"	3.0"-3.5"
<b>S (x=2)</b>	14.5"-17.0"	11.0"-12.5"	11.0"-13.0"	3.5"-4.0"
<b>M (x=3)</b>	17.0"-19.0"	12.5"-14.5"	13.0"-14.5"	4.0"-4.5"
<b>L (x=4)</b>	19.0"-20.5"	14.5"-16.0"	14.5"-16.0"	4.5"-5.0"
<b>XL (x=5)</b>	20.5"-22.5"	16.0"-17.5"	16.0"-17.5"	5.0"-5.5"

**Please fax the completed form, medical notes, and insurance cards to**  
**(434) 270-7278**