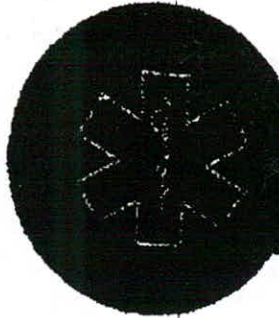


JK MED SOLUTIONS

Margarita Martinez



FAX 1-866-305-1994

MEDICAL NECESSITY REQUEST FORM

To: XXXXXXXXXX	From: JK MED SOLUTIONS
Fax: XXXXXXXXXX	Pages:
Phone: XXXXXXXXXX	Date: XXXXXXXXXX
Re: XXXXXXXXXX	CC:
<input checked="" type="checkbox"/> Urgent • <input type="checkbox"/> For Review • <input type="checkbox"/> Please Comment <input checked="" type="checkbox"/> Please Reply • <input type="checkbox"/> Please Recycle	

Comments:



Please make sure to fill out Step 2, 4 & 5 of the RX sheet.



Please reply and attach patient face sheet as well as patient **CHART NOTES** where it shows medical necessity for orthopedic braces.

This facsimile transmission contains confidential information intended for the parties identified above. If you received this transmission in error, please immediately notify me by telephone and return the original message to me at the address listed above. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.



**Statement of Medical Necessity for
KNEE BRACE**

PLEASE FAX BACK TO: **866-305-1994**

→ tied to a residential #

OFFICE: 619-367-0030

→ member for "Best Lead Solution Health Network"

Step 1 PATIENT INFORMATION AND AUTHORIZATION

Patient Name: XXXXXXXXXX	Medicare #: XXXXXXXXXX
Address: XXXXXXXXXX	Date of Birth: XXXXXXXXXX
City/State/Zip: XXXXXXXXXX	Phone: XXXXXXXXXX

Step 2 REASON FOR MEDICAL NECESSITY: (PLEASE REVIEW AND CHECK ALL THAT APPLY)
I expect that my patient requires the device listed below for one or more of the following medical reasons:

(Check) To improve instability and laxity of a joint (i.e. Varus/Valgus, Anterior/Posterior)

(Check) To help facilitate healing after a recent injury

(Check) Surgical procedure to the knee

Step 3 Products Ordered

HCPCS Code:	Product Name	Please Check	Qty	R/L/BL	Size
L1851	Universal Hinged Knee Brace-With L2397 Suspension Sleeve	<input type="checkbox"/>			

Step 4 Knee Diagnosis

M17.0 Bilateral Primary Osteoarthritis (Check)

M17.4 Bilateral Secondary Osteoarthritis of knee (Check)

M17.11 Unilateral Primary Osteoarthritis -Right Knee (Check)

M17.12 Unilateral Primary Osteoarthritis -Left Knee (Check)

M06.861 (R)(Check) / M06.862 (L) (Check) Rheumatoid Arthritis of the Knee

Additional Diagnosis:

IMPORTANT: PER INSURANCE GUIDELINES, PLEASE RETURN WITH A COPY OF THE PATIENT'S MEDICAL RECORD ASSOCIATED WITH THE REQUESTED PRODUCT.
 Providing medical records of patients to a healthcare provider without prior authorization is within the scope of compliance with HIPAA according to 45 CFR 164.506.

Step 5 Physician Information

I have reviewed the Rx above and found the information to be accurate. I certify the medical necessity to facilitate management of this patient's diagnosis. This Rx accurately reflects the patient's condition, my prescription for a knee brace and is substantiated by medical record

Print Physician Name: ~~XXXXXXXXXX~~

Physicians Signature _____ Date: _____

Address: ~~XXXXXXXXXX~~

City: XXXXXXXXXX	State: XXXX	Zip: XXXXXX
Phone #: XXXXXXXXXX	Fax #: XXXXXXXXXX	NPI #: XXXXXXXXXX