JK MED SOLUTIONS

Margarita Martinez

FAX 1-866-305-1994

MEDICAL NECESSITY REQUEST FORM

To: [redacted]	From: JK MED SOLUTIONS
Fax: [redacted]	Pages:
Phone: [redacted]	Date: [redacted]
Re: [redacted]	CC:

✖ Urgent • For Review • Please Comment ✖ Please Reply • 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.

[redacted]

Statement of Medical Necessity for

KNEE BRACE

→ tied to a residential #

→ number for "Best Lead Solution Health Network"

PLEASE FAX BACK TO: 866-305-1994

OFFICE: 619-367-0030

Step 1	PATIENT INFORMATION AND AUTHORIZATION
Patient Name: [redacted]	Medicare #: [redacted]
Address: [redacted]	Date of Birth: [redacted]
City/State/Zip: [redacted]	Phone: [redacted]

Step 2 **REASON FOR MEDICAL NECESSITY: (PLEASE REVIEW AND CHECK ALL THAT APPLY)**

I attest 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				

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 PATIENTS 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: [redacted]

Physicians Signature_____ **Date:**_____

Address: [redacted]		
City: [redacted]	**State:** [redacted]	**Zip:** [redacted]
Phone #: [redacted]	**Fax #:** [redacted]	**NPI #:** [redacted]