Physician:					Surgery Date:		A	Acct Rep	:	
Patient Name	e:				Patient SS#		F	Fax: (949) 251-51	120
***DOS:	Location:	Home	Sx Ctr.	Doctor	Phys.Therapy Other	Time:	C	ell	e.	1
gnosis/ICD9:		Home	br eu.		erred Vendor is T			154045707		mmakena.com
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RACING	Right	Lef	t 📋		Prefabricated (OT)					
Ligament Kn	nee 🗌 Ca	rtilage K	nee	Unload	er/OA Knee 🗌 Medial	Lateral		Post-op Kn	ee Brace w	/ ROM
					rtificate of Medical Nec					
					ed in the patient's medical ALL conditions that apply:	record (i.e., chart	notes). Pl	ease attach	ALL suppor	rting documentation
Alleviate	pressure on n	nedial or			Meniscal cartilage d			ligamentou		on
	al knee arthro d ROM requ		nost sur	ory	Aseptic necrosis o	f tibia/fibula	U Tib Other	ial plateau	racture	
	u KOlvi lequ	irements			BRACES, check ALL	the conditions tl				
			culatory,	or cutaneou	us status that requires a c	ustom				
Deformi	ity of the leg	or knee t	hat prech	ides fitting	with a prefabricated orth	osis Disprop	ortionate	size of thig ssive soft ti	h & calf	
	e, cannot fit ir					Other	uant/exce	ssive son u	ssue	
			Descril	e ALL con	ndition(s) that pertain t			pecific.		
Custom Brac	ce Prescribin	ng Infor	mation (ATTACH	CHART NOTES FOR	R MEDICARE))			
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I, the undersigned, confirm the order for the above named patient. I also certify that the prescribed treatment is medically reasonable and necessary in reference to accepted standards of medical practice within the community for treatment of this patient's condition.

Doctor	Signature
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