NextGen
Medical Supplies, Inc.

Prescription Authorization
Signature Required

RX FOR KNEE BRACE
PLEASE FAX TO: (888) 613-5719

ID:

PRESCRIPTION DATE:

A. PATIENT INFORMATION	B. PHYSICIAN INFORMATION
Name: **Address:** **Phone#** **DOB:**	**Name:** **Address:** **NPI** **PHONE#** **FAX#:**

Rx

AFFECTED KNEE*

☐ **LEFT** ☐ **RIGHT** ☐ **BILATERAL**

EQUIPMENT REQUESTED BY PATIENT (Please Initial any Changes)

☐ **L1833 Knee Orthosis, adjustable knee joints, prefabricated, off-the-shelf**

Length of Need (Lifetime unless otherwise specified): _____

DIAGNOSIS

☐ **M17.10, M17.5 Osteoarthritis, Involving Lower Leg**

☐ **M17.9 Osteoarthritis of Knee, Unspecified**

☐ **Additional Diagnosis** _____

MEDICAL NECESSITY

☐ To improve instability and laxity of a joint during ambulation, to facilitate healing after a recent injury or surgery.

SIGNATURE & DATE - By signing below, I confirm the medical supplies herein are medically necessary and that this prescription is valid for NextGen Medical Supplies Inc. I have had a face-to-face encounter with this patient within the last 6 months and have documented the condition related to this order in their medical record. I will furnish substantiating medical records upon request.

Physician Signature: _____ **Date:** _____/_____/_____

Printed name and NPI required of signing physician if different from provider printed above

Printed Name: _____ **NPI:** _____

Start Date: _____

IMPORTANT: RETURN WITH A COPY OF THE PATIENT'S MEDICAL RECORD ASSOCIATED WITH THE REQUESTED PRODUCT

Contact US:
Customer Service: (888) 557-7085
Nextgenmeds.com

PLEASE FAX TO: (888) 613-5719

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