



Equipment Request Form

Phone: 586-778-2500
Fax: 866-565-5190

Prefabricated Knee Orthoses
(Non-Adjustable & Adjustable Joints)

Per Medicare requirements, a SIGNED PHYSICIAN'S ORDER is required PRIOR TO delivery.
Please answer all questions below and return to Renaissance Medical. In addition, please make sure a signed
copy is kept in your patient's file.

Patient Full Name: _____ Date of Birth: _____

Address City/St/Zip: _____

Medicare # _____ Other Ins Type & # _____

Referring Facility/Name: _____ Contact Name: _____

Deliver To: [] Facility [] Home Requested Delivery Date: _____ Approx Time: _____

Length of need (Months) (99 = Lifetime): _____

Table with 2 columns: Description of orthosis and Requirement. Includes items like 'Elastic with stays, joints, or pads, prefabricated' and 'Single upright, thigh and calf, with adjustable flexion and extension joint prefabricated'.

- 1. Will the ordered knee orthosis treat an illness or injury OR improve the function of a malformed body member?
2. Does the patient have one or more of the following: unicompartmental osteoarthritis, meniscal cartilage derangement, knee ligamentous disruption, failed total knee arthroplasty, aseptic necrosis of tibia/fibula, tibial plateau fracture
3. Has the patient had recent surgical intervention on the ligaments of the knee requiring range of motion limitations?
4. Is the patient ambulatory AND has knee instability due to ligament insufficiency/deficiency or reconstruction?

Diagnosis(es) that qualify the need of item delivered: _____

Ordering Physician, PA, or Nurse Practitioner Name (Please Print): _____

Ordering Physician, PA, or Nurse Practitioner Signature: _____ Date: ____/____/____

NPI: _____

Please Fax This Page with Patient Demographics To: 1-866-565-5190