Rx: Certificate of Medical Necessity and Written Confirmation of Physician Order to

Bio DYNAMIC TECHNOLOGIES

Fax: 1-800-866-8011
www.biodynamictech.com

Date: ____________________

Patient Name: ______________________________ DOB: ______________

Address: ____

Home Phone: __________________ Cell Phone: ____________________

Patient Diagnosis: ____

ICD10 Code: ____ DOS: ______________________________________

Surgical Procedure: ____

PRODUCTS PRESCRIBED: GUARDIAN REHABILITATORS *(Check one) – No Substitution*

❑ **Guardian Sport Rehabilitator:**

Plus extension assist and protective undersleeve

____ Left ____ Right

____ Medial Unloader ____ Lateral Unloader

❑ **Guardian Sport PCL Rehabilitator Brace:**

Plus extension assist and protective undersleeve

____ Left ____ Right

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❑ **Guardian Sport EXT Rehabilitator:**

Plus extension assist and protective undersleeve

____ Left ____ Right

Eliminates Quadriceps Avoidance gait

- Ideal for post-surgery extension deficit therapy
- Ordered for knee instability due to extension deficit and generalized muscle weakness

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INSURANCE COVERAGE REQUIREMENTS

Patient is ambulatory. Weakness or deformity of the knee. Knee requires stabilization. Recent injury OR surgical procedure on knee. Knee joint laxity (must be documented by examination of the beneficiary and objective description of level or degree of joint laxity). Instability must be present.

❑ *Covered for a beneficiary who is ambulatory and has knee instability due to a condition specified in the ICD-10 codes that support medical necessity.*

❑ *Knee instability must be documented by examination of the beneficiary and objective description of joint laxity (e.g., Varus/ Valgus instability, anterior/posterior drawer test). Objective test results must be stated in the physician's notes.*

Physician Name:______________________________ **Physician NPI:**______________ **Physician Signature:**______________________________

I certify that I am the physician identified on this form. The above prescribed equipment is medically indicated and in my opinion is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition and is not prescribed as "convenience" equipment. I certify that the Patient/Caregiver has successfully completed, or will be trained on, the proper use of products as prescribed on this written order. The product lists, the physician's notes and other supporting documentation will be provided to the Supplier or its Authorized Distributor upon request. I ask that there be no equipment substitutions for the devices prescribed.

Fax complete form, patient's demographics, chart notes, and all insurance information to: 1-800-866-8011