



Knee Brace Preauthorization Request (Provider)

Participant: _____ **SSN:** _____

Patient: _____ **Date:** _____

The Plan covers services considered reasonable and necessary in connection with the diagnosis and treatment of any non-industrial illness or injury. Benefits are provided for **Standard** (off-the-shelf) knee braces when ordered by the treating physician.

Custom-made braces are covered only when physical characteristics of the patient make a standard brace inappropriate. These include tall or short stature, obesity, varus or valgus deformity, or other specific reasons that a standard brace would not be effective. The information provided below will assist us in expediting your request.

Diagnosis: _____

Other clinical data: _____

Type of Brace Prescribed: STANDARD CUSTOM-MADE (Complete data below)

Physical Examination:

Height: _____ Degree of Instability: _____

Weight: _____ Degree of Varus or Valgus: _____

Other Medical Considerations: _____

Your cooperation is appreciated.

Physician's Name: _____ **License #** _____

Address: _____

Telephone: _____ **FAX** _____

Physician's Signature

Date