PHYSICIAN ORDER SHEET – Certificate of Medical Necessity

Outside Referral ☐

Patient Name: ________________________________ Date of Birth: __________________

X-Ray	ICD-10 DIAGNOSIS
☐ RIGHT KNEE A-P view Lateral view	☐ M17.11 Unilateral Primary Osteoarthritis, Right knee ☐ M17.31 Unilateral Post-traumatic Osteoarthritis, Right knee
☐ LEFT KNEE A-P view Lateral view	☐ M17.12 Unilateral Primary Osteoarthritis, Left knee ☐ M17.32 Unilateral Post-traumatic Osteoarthritis, Left knee
☐ RIGHT AND LEFT KNEE A-P view Lateral view	☐ M17.0 Bilateral Primary Osteoarthritis of knee ☐ M17.2 Bilateral Post-traumatic Osteoarthritis of knee

I am the physician who ordered the above studies and certifies the medical necessity of this order.

Physician Signature ____________________________________ Date ________________

Please fax copy of report to: 1-888-625-0309

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