# EQUIPMENT REPLACEMENT FORM
## (For Reasonable Useful Life)

Patient Name: ______________________________________________

Facility Name: ____________________________ Location: __________________

Description of Equipment Being Replaced: ________________________________

______________________________________________________________

Date of service for original Product: _____________________________________

Reason for Replacement:

☐ Change in Condition (Ex: Change in Weight, ROM, Dx, etc.) ______________

______________________________________________________________

☐ Damaged, cannot be repaired nor applied.
(Describe the damage / Explain the loss): ____________________________

______________________________________________________________

| ______________________ | ______________________ | __________ |
|---|---|---|
| **Signature and Title** | **Print Name** | **Date** |

## Updated CMN for Continuous use:

**Requested Equipment** ______________________________________

Primary Physician's Name: ____________________________ NPI: ______________

Address: ________________________________________ City: __________________

State: _____ Zip: __________ Phone: (____) ____-______ Fax: (____) ____-______

**Diagnosis:**

- ☐ M24.531 Wrist Contracture (Rt)
- ☐ M24.532 Wrist Contracture (Lt)
- ☐ M24.541 Finger Contracture (Rt)
- ☐ M24.542 Finger Contracture (Lt)
- ☐ M24.521 Elbow Contracture (Rt)
- ☐ M24.522 Elbow Contracture (Lt)
- ☐ M24.561 Knee Contracture (Rt)
- ☐ M24.562 Knee Contracture (Lt)
- ☐ M24.571 Plantar Flexion Contracture (Rt)
- ☐ M24.572 Plantar Flexion Contracture (Lt)
- ☐ _______ Other

**RX:**

- ☐ Hand Splint
- ☐ Elbow Splint
- ☐ Knee Splint
- ☐ Ankle Foot Orthosis

______________________ __________
**Physician's Signature** **Date**

______________________________
**Print Physician's Name**