**PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FOR ANKLE/FOOT ORTHOSIS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Please Send RX Form & Pertinent Chart Notes** | | | **Fax No: (305) 390 3669** |
|  |  | **PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS** | | |
|  |  |  |  |  |
| Date: | ${order\_date} |  |  |  |
| First: | ${fname} | Last: ${lname} | Physician Name: ${phy\_name} | |
| DOB: | ${dob} |  | NPI: | ${phy\_npi} |
| Address: |  | ${address} | Address: | ${phy\_address} |
| City: |  | ${city} | City: | ${phy\_city} |
| State: |  | ${state} | State: | ${phy\_state} |
| Postal Code: |  | ${postal\_code} | Postal code: | ${phy\_postal\_code} |
| Patient Phone Number:  ${phone\_num} | | Policy #: ${policy\_num} | Phone Number: ${phy\_phone\_num} | |
| Primary Ins: | ${primary\_ins} | Fax Number: ${phy\_fax} | |
| Private Ins: | ${private\_ins} | Policy #: - |  |  |
| Height: ${height} | Weight: | ${weight} |  |  |

*This patient is being treated under a comprehensive plan of care for ankle and/or foot pain.*

*I, the undersigned; certify that the prescribed orthosis is medically necessary for the patient’s overall well-being. This patient has suffered injury and/or undergone surgery. In my opinion, the following ankle foot orthosis products are both reasonable and necessary in reference to treatment of the patient’s condition and/or rehabilitation. My patient has been in my care regarding the diagnosis below. This is the treatment I see fit for this patient at this time.*

**DIAGNOSIS:** Provider can simply cut off the diagnosis which they don’t find appropriate

Primary osteoarthritis, right ankle and foot (M19.071)

Primary osteoarthritis, left ankle and foot (M19.072)

Unspecified disorder of synovium and tendon, unspecified site (M67.90)

Other instability, right ankle and foot (M25.371)

Other instability, left ankle and foot (M25.372)

Displaced trimalleolar fracture of unspecified lower le­g (S82.853A)

Spontaneous rupture of other tendons, unspecified ankle and foot (M66.879)

Pain in right ankle and joints of right foot (M25.571)

Pain in left ankle and joints of left foot (M25.572)

Flat foot [pes planus] (acquired), unspecified foot (M21.40)

Sprain of unspecified ligament of right ankle (S93.401)

Sprain of unspecified ligament of left ankle (S93.402)

Other /Explain (Include code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AFFECTED AREA:** ANKLE/FOOT: Left **** Right ****

***Our evaluation of the above patient has determined that providing the following Ankle/Foot orthosis product will benefit this patient:***

**DISPENSE:**

L1971: ANKLE FOOT ORTHOSIS (AFO), PLASTIC OR OTHER MATERIAL WITH ANKLE JOINT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

L3170: FOOT, PLASTIC, SILICONE OR EQUAL, HEEL STABILIZER, PREFABRICATED, OFF-THE-SHELF, EACH

Length of need is 99 months unless otherwise specified: \_\_\_\_\_ 6 - 99 (99= LIFETIME)

${phy\_signature} ${phy\_signed\_date}

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Name:** ${phy\_name} **NPI:** ${phy\_npi}