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| **Advanced Medical Supply** |
| **Phone: 866-994-2583** |
| **Fax 1st: 469-501-9073**  **Fax 2nd: 817-780-0212** |

**FAX**

**To:**

**Name: {{pcp\_name}}**

**Fax Number: {{pcp\_fax}}**

**From: no # pages: 2(including cover)**

**Name: Advanced Diabetic Supply**

**Fax Number: (469) 501-9073**

|  |
| --- |
| **Subject: {{name}}** |

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| **Message:**  **Please sign the prescription and return the fax along with the recent visit notes or the progress notes of the patient.**  **Thanks** |

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

PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS Fax No: **(817) 780-0212**

|  |  |
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| **Patient’s Information**  Date: {{date}}  Name: **{{name}}**  Address: {{address}}, {{city}}, {{state}}, {{zip}}  Phone: **{{phone}}**  DOB: **{{dob}}** Height:**{{height}}** Weight:**{{weight}}**  Primary Ins: {{insurance}}  Policy #: **{{medicare}}** | **Physician Information**  Physician Name: **{{pcp\_name}}**  Address: {{pcp\_address}}, {{pcp\_city}}, {{pcp\_state}}, {{pcp\_zip}}  Phone Number: {{pcp\_phone}}  Fax Number: {{pcp\_fax}}  NPI: **{{pcp\_npi}}** |

*This patient is being treated under a comprehensive plan of care for ankle/foot pain.  
I, the undesigned; certify that the prescribed orthosis is medically necessary for the patient’s overall well-being.  
This patient has suffered an injury or undergone surgery. In my opinion, the following 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 treatment I see fit for this patient at this time. I  
certify that this information is true and correct.*

**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 Others Tendons, Unspecified Ankle and Foot (M66.879)  
 Pain in Right Ankle and Joints of Right Foot (M25.571)  
 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 following ankle pain orthosis product will benefit this patient***

**DISPENSE:**  
L2136 ANKLE/FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL WITH ANKLE JOINT,  
PREFABRICATED  
L3170 HEEL CUP; HIGH-DENSITY POLYURETHANE (PU)  
Estimated length of need (# of months): \_\_\_\_\_\_\_ 6 – 99 (99=LIFETIME)

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated signed: \_\_\_\_\_\_\_\_\_