



MEDICAL SUPPLY

Voice: 1-800-657-4090

Fax: 1-866-626-7881

CERTIFICATE OF MEDICAL NECESSITY FOR
AFG Ankle Foot Gauntlet Stabilizer L1902

Patient's Name: HIC#:
Address: DOB:
Insurance Name:
Insurance Phone:
Phone:

AFG: RF LF Bilateral Shoe Size

Table with 4 columns: Indications for use, Code, Indications for use, Code. Rows include Ankle Pain & Support, Defective Circulation, Neuropathy, Diabetic/ Circulation, Arthritis, Arthritis, Rheumatoid, Unspecified Disorder of Ankle and Foot Joint, Pain, Joint involving Ankle and Foot, Joint Swelling.

This patient is being treated under a comprehensive plan of care for Diabetes / Foot Pain / Arthritis. I, the undersigned certify that the above prescribed is medically necessary for the patient's overall well being.

Prognosis:

Estimated length of need (# of months) (99 = lifetime)

Physician's Signature: Date signed:

Physician Name: NPI:

Address:

Physician Phone: Fax: