MEDICAL SUPPLY

Voice: 1-800-657-4090
Fax: 1-866-626-7881

CERTIFICATE OF MEDICAL NECESSITY FOR
Thermoskin AFO Ankle Foot Orthosis

Patient's Name: _____ HIC#: _____

Address: _____ DOB: _____

_____

_____ Insurance Name: _____

Insurance Phone: _____

Phone: _____

Ankle Foot Stabilizer (L1902) **Ankle Lok (L1902)** **Arch Lok (L1906)** **Strap Lok (L1906)**
Swede-O Adjustable Night Splint (L4396) **Waking Boot (L4360)**

AFO: RF _____ LF _____ Bilateral _____ Shoe Size _____

Indications for use:	**Code:**	**Indications for use:**	**Code:**
1. Ankle Pain & Support _____	729.50	3. Unspecified Disorder of Ankle and Foot Joint _____	719.97
2. Pain, Joint involving Ankle and Foot _____	719.47	4. Joint Swelling _____	719.07

5. Other: _____

Please check all that apply:

1. The patient could not be fit with a prefabricated AFO, or
2. The condition necessitating the Orthosis is expected to be permanent or of longstanding duration (more than 6 months), or
3. There is a need to control the knee, ankle or foot in more than one plane, or
4. The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
5. The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

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. In my opinion the AFG is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation.

Prognosis: _____ Estimated length of need (# of months): _____ (99 = lifetime)

Physician's Signature: _____ **Date:** _____

Physician Name: _____ NPI: _____

Address: _____

_____

Physician Phone: _____ Fax: _____