STEPWELL CUSTOM AFO PRESCRIPTION (STEP004)

PATIENT NAME: _____D.O.B._____

Circle appropriate extremity: Left Right Bilateral

L1940 ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL, CUSTOM-FABRICATED

L2330 ADDITION TO LOWER EXTREMITY, LACER MOLDED TO PATIENT MODEL, FOR CUSTOM FABRICATED ORTHOSIS ONLY

L2820 ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, BELOW KNEE SECTION

DIAGNOSIS CODE **DIAGNOSIS DESCRIPTION**

1._____

2._____

3._____

4._____

THIS SERVICE IS MEDICALLY NECESSARY TO:
(Check all that apply)

_____Prevent/Correct deformity _____Reduce axial load

_____Protect joint _____Maintain correct alignment

_____Improve ambulation _____Immobilize and support lower extremity

_____Treat fracture _____Prevent further injury

PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY:

I certify that this custom orthosis is reasonable and medically necessary in the treatment of this patient. Custom fabrication is necessary to accommodate this patient's body shape and to achieve maximum rehabilitation success.

PHYSICIAN SIGNATURE_____DATE_____

PHYSICIAN NAME_____NPI#_____

PHYSICIAN ADDRESS_____

_____

PHONE/FAX_____