The DiABETiC Shoppe
1068 Factory Drive ~ Charleston, MS 38921
Toll-Free Phone: 1-888-571-3533 ~ Toll-Free Fax: 1-800-520-8117

Ankle Foot Orthosis Prescription Form

Step 1

Patient ID#:_____ Effective Date:_____

Patient Name: Mr/Ms_____ SS#:_____

Address:_____ City:_____,_____ Zip:_____

Phone:_____ Birthday:_____

Primary:_____ Secondary:_____

Policy #:_____ Policy #:_____

Insulin Treated? Yes _ No _ **ICD-10 Diagnosis Code:.**

- ❑ Osteoarthritis-Localized…M19.079
- ❑ Articular Cartilage Disorder…M24.173
- ❑ Sprain, Tibiofibular Ligament, Distal…S93.439A
- ❑ Arthritis Ankle & Foot…M12.9
- ❑ Osteochondritis Dissecans…M93.20
- ❑ Other (Please specify) _____

Patient Sizing and Item Description

Please choose the size based on Patient's Shoe Size

Step 2

Size	Shoe Size
❑ Small	Male <8/Female <9.5
❑ Medium	Male 8 to 12/Female 9.5 to 13.5
❑ Large	Male 12+ / Female 13.5+

Item Description & HCPCS Code:
Ankle Foot Orthosis – L1971: Plastic or other material with ankle joint, prefabricated, includes fitting and adjustment
Ankle Foot Orthosis for Foot Drop – L1951: Ankle foot orthosis, spiral, (institute of rehabilitative medicine type), plastic or other material.

Please specify Ankle/Foot for treatment:
❑ - Right ❑ - Left ❑ - Both

Specify Ankle Brace (L1971) or Drop Foot Device (L1951)
❑ Ankle (L1971) ❑ Drop Foot (L1951)

REASON FOR MEDICAL NECESSITY AND LENGTH OF NEED:

MEDICARE REQUIRES A REASON(S) FOR A ANKLE FOOT ORTHOSIS. I confirmed that I have seen this patient within the last six (6) months to evaluate their above mentioned diagnosis, have reflected need in their most recent medical chart, have identified the reason(s) for using this orthosis below:

- ❑ Twisting Injury Leading to Fracture
- ❑ Inversion Injury Sprain of Deltoid Ligament
- ❑ Ankle Instability
- ❑ Ligament Instability
- ❑ Twisting Injury to High Ankle Sprain
- ❑ OTHER_____

LENTH OF NEED IS **99 MONTHS** (unless specified): _____ months

Step 3

Print Physician's Name:_____ Ph #:_____

Physician Signature:_____ Date:_____

NPI:_____ DEA#_____ City:_____, ST:_____

By signing above, I agree to obtain the original, signed copy of this document in my medical records. My medical records and recent charts substantiate I am treating this patient under a comprehensive care plant for the above mentioned diagnosis and the patient is able to use this item herein ordered to manage his/her condition. This order accurately reflects the patient's documented diagnosis, condition, prescribed treatment and testing regimens.

Accredited by
JCAHO