



ANKLE BRACE DETAILED WRITTEN ORDER

Patient Information

Name:

Insurance ID:

Date of Birth:

Insurance Name:

Phone Number:

Gender:

Address:

Physician Information

Name:

Phone:

Email:

NPI:

Fax:

Address:

Equipment to Prescribe

- L1906 Ankle-foot orthoses (AFO) - Multiligamentous ankle support, prefabricated, off-the-shelf. This brace(s) will be covered for ambulatory beneficiaries with weakness or deformity of the foot and ankle.

2 Diagnosis

Diagnosis Code(s): _____

3 Which side requires an ankle brace?

- Both Left Right

4 What is the medical reason for the ankle brace(s)?

- Require stabilization for medical reasons, and, Have the potential to benefit functionally.

5 Please send medical records to support medical necessity of the ankle brace.

I certify that I am the physician identified in the above section and I certify that information contained in this document reflects the patient's condition and is accurate to the best of my knowledge.

6 Date: _____

7 Physician Signature: _____