800.838.3560
866.292.6645

Eden MEDICAL SUPPLY

ANKLE BRACE DETAILED WRITTEN ORDER

Patient Information

Name:
Date of Birth:
Phone Number:
Address:

Insurance ID:
Insurance Name:
Gender:

Physician Information

Name:
NPI:
Address:

Phone:
Fax:

Email:

Equipment to Prescribe

☐ **L1906 Ankle-foot orthoses (AFO)** - Multigamentous 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?

Side: ☐ Both ☐ Left ☐ Right

Size: ☐ Small ☐ Medium ☐ Large

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: _____