Vito's Pedorthic Center
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Statement of Medical Necessity

Patient Name:____________________________
HICN:____________________________________
DOB:____/____/____
Duration of Usage (check applicable): ☐ 12 MONTHS ☐ 1 YEAR ☐ 5 YEARS
Quantity (check applicable): ☐ Unilateral (R/L) ☐ Bilateral

AFO TYPE

- ☐ **L1960** Ankle foot orthosis, posterior solid ankle, plastic, custom-fabricated
- ☐ **L1970** Ankle foot orthosis, plastic with ankle joint, custom-fabricated
- ☐ **L1932** Ankle foot orthosis, rigid anterior tibial section, total carbon fiber, prefab including fitting and adjustment
- ☐ **L2275** Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined
- ☐ **L2820** addition to lower extremity orthosis, soft interface, below knee
- ☐ **L4631** Crow boot: varus/valgus correction, rocker bottom, anterior tibial, soft interface, custom arch support.
- ☐ **L2330** Addition to lower extremity, lacer molded to patient model for custom fabricated orthosis only
- ☐ **L2210** Addition to lower extremity, dorsiflexion assist (plantar flexion resist), dual joint

I hereby certify that Mr. / Ms. ___________________________ qualifies for and will benefit from the product designated above from Vito's Pedorthic Center based on the following criteria: (check all that apply)

- ☐ Instability in gait with recurrent sprains or falls
- ☐ Significant impairment of gait due to pain or ankle / foot deformity
- ☐ Significant weakness, ataxia, or gait abnormality
- ☐ Partial or complete paralysis of one or more leg muscles

Necessity of Ankle Foot Orthotic molded to patient model:
A custom (vs. prefabricated) ankle foot orthosis has been prescribed based on the following criteria which are specific to the condition of this patient: (check all that apply)

- ☐ There is need to control the ankle or foot in more than one plane
- ☐ The patient could not be fitted with a prefabricated AFO
- ☐ The condition necessitating the orthosis is expected to be permanent or of longstanding duration (6+ months)
- ☐ The patient has documented neurological, circulatory, or orthopedic condition that requires custom fabrication over a model to prevent tissue injury

The goal of this therapy: (check all that apply)

- ☐ Improve lower extremity stability
- ☐ Decrease risk of fall
- ☐ Decrease pain
- ☐ Improve mobility

I hereby certify that the ankle foot orthotic described above is a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminated motion in a diseased or injured part of the body. It is designed to provide support and counterforce on the limb or body part that is being braced. The custom molded ankle foot orthosis is both reasonable and necessary in reference to accepted standard of medical practice in the treatment of the patient condition and rehabilitation.

Signature of Prescribing Physician:______________________ **NPI:**________________ **Date:**___/___/___

⇨ DPM/MD/DO please attach clinical notes that support the Statement of Medical Necessity.
If clinical notes do not support the Statement of Medical Necessity it will be noted as incomplete.
The qualifying conditions that are marked in the list above must also be reflected in the clinical notes. ⇦