

LETTER OF MEDICAL NECESSITY AND PHYSICIAN ORDER FORM

Patient Name: _____ Phone: _____ DOB: _____

Dx:

- ___ Achilles contracture 727.81
- ___ Achilles tendinitis/bursitis 726.71 **
- ___ Ankle fusion 755.69
- ___ Apophysitis 732.5
- ___ Arthritis (Osteo) 719.67
- ___ Arthritis (Rheum) 714.0 **
- ___ Arthropathy- foot & ankle Unspecified 716.97 **
- ___ Bunion 727.1 **
- ___ Calcaneal/Heel spur 726.73
- ___ Cavovarus foot deformity (acq) 736.75
- ___ Cavus foot deformity (acq.) 736.73
- ___ Charcot Arthropathy 713.5
- ___ Charcot-Marie-Tooth: 356.1
- ___ CVA-other late effects: 438.9
- ___ Diabetes 250. _____ (must include 2 digits) **
- ___ DJD 715.0, 715. _____
- ___ Drop Foot-other: 736.79
- ___ Equinus foot 736.72
- ___ Hallux Rigidus 735.2
- ___ Hallux Valgus (acq.) symptomatic 735.0
- ___ Leg Length Discrepancy acq. 736.81
- ___ Metatarsalgia 726.70
- ___ Neuroma 355.6 **
- ___ Peripheral vascular disease unspecified 443.9
- ___ Peroneal Tendonitis 726.79 **
- ___ Pes planus (cong.) 754.61
- ___ Plantar fasciitis 728.71 **
- ___ Sesmoiditis 733.99
- ___ Stress fracture unspec. 733.10
- ___ Synovitis tenosynovitis 727.9 **
- ___ Tarsal tunnel 355.5 **
- ___ Tibialis Tendonitis (posterior or anterior) 726.72 **
- ___ Tenosynovitis foot & ankle 726.06 **
- ___ Unspecified deformity of the ankle/foot, acq.: 736.70
- ___ Other: _____

Rx:

Foot orthoses (bilateral): (BCBS FEP requires ICD-9 with ** at left)

- ___ Dress orthoses: Flats or Heels (Cobra) (L3020)
- ___ Casual/ everyday (Semi-Rigid) (L3000)
- ___ Sport (all Semi-Rigid except Soccer/Cycling) (L3000)
 - General sport
 - Runners
 - Basketball
 - Soccer/cycling (rigid, low profile)
- ___ Highly Inverted ____° 10/15/20/25(for PTTD/ pronation)
- ___ Hallux Rigidus Type (carbon fiber hallux support)
- ___ Accommodative: Diabetic RA (L3020)
- ___ Toe Filler w/arch support (L5000) L R (choose level)
- ___ V49.73 Partial foot, ___V49.71 Hallux, ___V49.72 Lesser toe(s)

Shoes (bilateral):

- ___ Shoes w/ depth/stability (Casual/ Dress/ Sandal)
- ___ Athletic Shoes
- ___ Diabetic OTS Shoes incl. OTS inlays (3 2 1 pairs)
- ___ Custom Molded incl. custom orthoses (3 2 1 pairs)

Notes: _____

Modifications:

- ___ Stabilizer (Lateral/ Medial) Lt. Rt.
- ___ Rocker Soles: Lt. Rt. Shank? (Y / N)
(balance/elevate other side if needed after rocker)
- ___ Elevation of _____ in. Lt. Rt.

AFO: (also requires LMN for AFOs)

- ___ Arizona AFO (for PTTD, DJD, etc.) Left Right Bilateral
- ___ Other AFO (Shorty, Solid, DU, PTB) Left Right Bilateral

Other:

- ___ Compression Hose mmhg -8-15 -15-20 -20-30 -30-40
- # pair: _____ knee # pair: _____ thigh # pair: _____ waist
- ___ Carbon Foot Plate Left Right Bilateral

CERTIFICATE OF MEDICAL NECESSITY

Instructions: _____

Prognosis with device(s):

- ___ Poor ___ Guarded
- ___ Good ___ Excellent
- ___ Other: _____

Frequency of Use:

- ___ Waking Hours—All Day/Regular Use
- ___ Waking Hours—Strenuous Use
- ___ Sleeping
- ___ Other: _____

Duration of use:

- ___ Temporary (<3 months)
- ___ 3 to 12 months
- ___ Over 12 months/lifetime
- ___ Other: _____

Expected Therapeutic Effect:

- ___ Reduce pain/increase comfort
- ___ Stabilize joint/prevent further complications
- ___ Maintain/improve current functional status/gait
- ___ Unload pressure/promote healing
- ___ Reduce edema/promote circulation

I authorize the items/services shown herein and certify that the devices are medically necessary for this patient and that the information provided herein is true, accurate, and documented in the patient's clinical notes. (Signed below)

Physician Name

Date

Physician Signature

NPI

Physician Address

Physician Phone

Physician Fax

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