

**PHYSICAN PRESCRIPTION and STATEMENT OF MEDICAL NECESSITY FOR
ANKLE – FOOT ORTHOSES**

Patient Name: _____ **SSN:** _____

Date of Service: _____ **Affected:** ___ **right** ___ **left** ___ **bilateral**

Diagnosis:

___ tibia contusion 924.10 ___ tibia fracture 823.20 ___ fibula fx 823.21 ___ leg laceration 891.1 ___ crush injury 928.21
___ deltoid sprain 845.01 ___ lateral ankle sprain 845.09 ___ med. mal fx 824.0 ___ lat mal fx 824.2
___ bimal fx 824.4 ___ foot crush 928.2 ___ Achilles sprain 845.09 ___ tarso-mt sprain 845.11 ___ metatarsal fx 825.25
___ calcaneus fx 825.0 ___ ant-post tib tendonitis 726.72

Product Prescribed

___ Short MaxTrax Air Ankle Walker 11-1380x / L 4360 ___ Tall Max Trax Air Ankle Walker 11-1371x / L 4360
___ Stabilizing Ankle Brace 11-0451 / L 1902 ___ Surround Air Ankle Brace 79-81707 / L 1906
___ Velocity Ankle Brace 11-15xx / L 1971 ___ Plantar Fasciitis Night Splint 79-9775x / L 4396
___ Rocker Cast Boot 79-78111 / L 3265

Weakness or Deformity:

___ Swelling ___ Limited Motion ___ Inability to bear weight ___ Pain on weight bearing

Necessity for AFO:

___ Pain Relief ___ Stabilization of tissue ___ To permit weight bearing ___ Stabilize bone while healing

Potential Functional Benefit:

___ Ability to function while healing ___ Protection while bearing weight ___ Protect healing tissue from environment

By my signature, I am prescribing the item listed above. In my judgment, the above prescribed item is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

Douglas E. Duncan, MD NPI 1548267156

Date

Douglas A. Waldman, MD NPI 1902801871

Date

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