


Supramalleolar AFO

 **Howard**
Orthotics and Prosthetics

Roger R. Howard, CPO
Director

Name: _____ DOB: _____
Address: _____
Referring Physician: _____
Rx: _____

**SAMPLE
Rx**

**CUSTOM MOLDED
LEFT/RIGHT
SUPRAMALLEOLAR AFO**

ICD-10 Dx: _____

Signature: _____
Date: _____ NPI: _____

DESIGNS FOR YOUR LIFESTYLE

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At a minimum, the following needs to be in **Doctor's Progress Note** to ***establish medical necessity*** in order for a patient's health insurance to cover the cost of custom molded supramalleolar AFO:

1. Patient is ambulatory.
2. Patient exhibits weakness or deformity of the foot and/or ankle. Patient has the potential for functional benefit with orthotic treatment.
3. At least **one** of the following criteria must be met for coverage purposes:
 - A prefabricated foot orthosis was fit to the patient and deemed inappropriate.
 - The condition necessitating the need for the orthosis is expected to exist for more than 6 months.
 - The ankle, foot, and/or knee require(s) control in more than one plane.