UCBL

Howard Orthotics and Prosthetics

Roger R. Howard, CPO
Director

Name: ______________ DOB: __________
Address: ______________
____
Referring Physician: ______________

SAMPLE Rx

Rx:

CUSTOM MOLDED
LEFT/RIGHT
UCBL

ICD-10 Dx: ______

Signature: ______________
Date: ___________ NPI: __________

DESIGNS FOR YOUR LIFESTYLE

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

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 **<u>one</u>** 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.