CERTIFICATE OF MEDICAL NECESSITY

PATIENT: _____

DIAGNOSIS: _____

THE ABOVE NAMED PATIENT REQUIRES: _____

REASON:

- ☐ DEFORMITY HAS PROGRESSED
- ☐ IMPROVE / MAINTAIN / CONTROL ALIGNMENT
- ☐ PROTECT A BODY SEGMENT FROM FURTHER INJURY
- ☐ REQUIRED FOR STANDING OR TRANSFER
- ☐ IMPROVE FUNCTIONAL STABILITY
- ☐ SLOW OR PREVENT PROGRESSION OF DEFORMITY
- ☐ OUTGROWN / POORLY FITTING
- ☐ PAIN LEVEL
- ☐ HOME EXERCISE TREATMENTS TRIED
- ☐ PHYSICAL THERAPY TRIED
- ☐ ANY XRAY'S OR MRI'S PERFORMED (PLEASE INCLUDE NOTES)
- ☐ _____

THE CONDITION IS: ☐ TEMPORARY ☐ PERMANENT ☐ UNKNOWN

TO BE USED:

- ☐ DURING AMBULATION
- ☐ NIGHT ONLY
- ☐ 16-21 HOURS
- ☐ DURING RECREATIONAL ACTIVITIES
- ☐ UNDER SUPERVISED CARE

PROGNOSIS:

- ☐ FUNCTIONAL STATUS OF PATIENT WILL BE IMPROVED
- ☐ DEFORMITY WILL BE CONTROLLED / REDUCED
- ☐ PATIENT WILL BE RETURNED TO ACTIVITIES OF DAILING LIVING

PLEASE INCLUDE CLINICAL NOTES FROM THE VISIT IN WHICH IT WAS DETERMINED THAT ORTHOTICS WERE REQUIRED.

DOCTOR: _____ NPI: _____

ADDRESS: _____

SIGNATURE: _____ DATE: _____

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