ONE SOURCE MEDICAL SOLUTIONS, INC.

One Company. Multiple Solutions.™

STATEMENT OF CERTIFYING PHYSICIAN FOR AFO-ANKLE FOOT ORTHOSIS

Patient:_____ **Phone**:_____

Address:_____ **City**:_____ **State**:____ **Zip**:_____

DOB:_____ **HICN**:_____ **Medicaid No**.:_____ **Date:_____**

I certify that all of the following statements are true:

1. **This patient has the following diagnosis - ICD-9 Code**

   1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

2. **This patient has one or more of the following conditions. (Circle all that apply):**

   a) Prevent/Correct deformity
   b) **Reduce axial load**
   c) **Protect joint**
   d) **Maintain correct alignment**
   e) **Improve ambulation**
   f) Immobilize and support lower extremity
   g) Treat fracture
   h) Prevent further injury

3. **I certify that this custom orthosis is reasonable and medically necessary in the treatment of this patient to achieve maximum rehabilitation success.**

PRESCRIPTION

Evaluate and perform comprehensive pedorthic assessment. Dispense:

Custom AFO-Ankle Foot Orthosis to accommodate this patient's body shape and achieve precise alignment for total contact fit.

Physician Signature: _____

Date Signed: _____

Physician Name (print): _____

Physician Address: _____

Physician NPI: _____ Physician UPIN: _____

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