AIM PLUS
MEDICAL SUPPLIES

Certificate of Medical Necessity of Certifying Provider for AFOs and KAFOs

Please fax form with Provider's Signature to 866-496-7054

PATIENT INFORMATION

Name: _____ Date of Birth ____/____/_____
Primary Phone: _____ Secondary Phone: _____
Address: _____ City/State/Zip: _____
Primary Insurance: _____ ID#: _____
Secondary Insurance: _____ ID#: _____
Contact Person (If other than Patient): _____

It is my expert opinion that HCPCS Code ___ L1902, ___L1906, ___ L1930, ___L1971, ___ L4350, ___ L4361, ___L4387, ___ L4397, ___L4398, and/or ___ Other HCPC _____ is medically necessary for the following reason(s). This prescription also acts as a Letter of Medical Necessity. (Check all that apply)

___ Beneficiary is ambulatory; **and** has a weakness or deformity of the foot and ankle; **and** requires stabilization of the foot and ankle for medical reasons; **and** has the potential to benefit functionality from the use of an AFO.
___ Other _____

Please include ICD-10 codes that apply:

_____ _____ _____ _____

*For Relevant ICD 10 Codes, See
https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsOrthopedics1.pdf

Duration: Patient has had this condition for a period of ____ month(s) ____ year(s). (Chronic = 3 months or more)
Estimated Length of Need ___ month(s) ____ 1-99 (99 = Lifetime)

Requested Product:

___ Falcon __*L1971 with Calf Extension or __ *L1906 without Calf Extension S to L
___ Aero Walker (High Top and Low Top) *L4361 Available in XS to XL
___ Low Profile Air Walker (High Top and Low Top) with cushioned heel *L4361 XS to XL
___ Low Profile Air Walker (High Top and Low Top) with metal uprights *L4361 S to L
___ Low Profile Walker (High Top and Low Top) with plastic uprights *L4387 XS to XL
___ Low Profile Walker (High Top and Low Top) with metal uprights *L4387 XS to XL
___ Advanced Ankle Helper Hinge Brace *L1906 XS to L
___ Quick Lace Ankle Brace *L1902 XS to XL
___ AO Stabilizer Ankle Brace *L1902 S to XL
___ Pediatric Walker *L4387 S to XL
___ Stabilizer Range of Motion Walker *L4387 XS to XL
___ PFS Night Splint *L4397 S to L
___ Dorsal Night Splint *L4397 S to XL
___ Podus Boot *L4397 S to XL
___ Air-Lite Night Splint *L4398 S to XL
___ Ankle Foot Orthosis *L1930 S to XL
___ Cool Foam Ankle Brace *L4350 R or C
___ Air-Gel Ankle Brace *L4350 R or C.
___ Air-Lite Ankle Brace *L4350 U
___ Other _____

*Suggested HCPC code

Please indicate: ___ Right (RT) ___ Left (LT) ___Both
Requested Size: ___ XS ___S___M___L___XL ___ Universal (U) ___ Regular (R) ___Child (C)

This patient is being treated under a comprehensive plan of care. I, the undersigned, certify that above prescribed is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item and will be made available upon request.

Provider Name (Print): _____ Provider NPI# _____
Provider Phone Number: _____ Provider Fax: _____
Provider Signature: _____ **Date**: _____