



DWO for Ankle Supports/Bracing

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622

DATE OF ORDER: _____

DATE OF LAST FACE TO FACE: _____

PATIENT INFORMATION

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____ Phone _____

Date of Birth _____ Emergency Contact _____ Emergency Contact Phone _____

REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name _____ Therapist Name _____

Clinic Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Therapist Email _____

PRODUCT PRESCRIBED

AFO, Static (Non-Ambulation), Night Splint, Circle one or both: RT or LT

L4397 Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, OTS

AFO, Non-Static (used during ambulation), Circle one or both: RT or LT

L1902 - Ankle foot orthosis, ankle gauntlet, prefabricated, off-the-shelf
L1906 - Ankle foot orthosis, multiligamentous ankle support, prefabricated, OTS

Ankle Brace, Circle one or both: RT or LT

L1971 - Ankle foot orthosis, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment

Pneumatic Walking Boot, Circle one or both: RT or LT

L4361 Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, OTS

Non-Pneumatic Walking Boot, Circle one or both: RT or LT

L4387 (L4386) - Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, OTS

Other Ankle Brace _____ Circle one or both: RT or LT

DIAGNOSIS

M24.573 Contracture, unspecified ankle

M24.576 Contracture, unspecified foot

M72.2 Plantar fascial fibromatosis

M47.817 Spondylosis without myelopathy or radiculopathy, lumbosacral region

Other:

(Any diagnosis that indicates the need for ankle/foot immobilization or foot drop)

PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried/considered and ruled out.

Physician Name _____ NPI# _____ Phone _____ Fax _____

Physician Address _____ City _____ State _____ Zip _____

Physician Signature _____ Date Signed _____