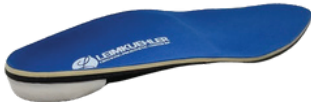


Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Custom Foot Orthotics**



**Custom UCBLs**



**Partial Foot (Toe Filler)**



**Type of Orthotic Base**

- Accommodative**       **Bilateral**  
 **Functional**       **Right**       **Left**

**Diagnosis**

- M21.6 – Other Acquired Deformities of Foot  
 M72.2 – Plantar Fasciitis  
 M76.829 – Posterior Tibial Tendon Dysfunction  
 M77.3 – Calcaneal spur  
 M77.4 – Metatarsalgia  
 Q66.7 – Cavus Foot  
 M19.079 – DJD (Osteoarthritis)  
 Other \_\_\_\_\_

**Duration of Use:**

- Lifetime Use: Patient is to wear orthotics daily, with periodic reassessment every 12 months  
 Other \_\_\_\_\_

**Medical Necessity:**

- Custom foot orthotics are medically necessary for the treatment due to diagnosis above. Conservative treatments, including over-the-counter orthotics, have failed to provide adequate relief. Custom orthotics will provide the necessary arch support and heel cushioning to alleviate pain and prevent further deterioration of the condition.

**Other / Notes** \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Physician Name \_\_\_\_\_ NPI# \_\_\_\_\_

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