Request for Statement of Certifying Physician for Ankle Foot Gauntlets

Patient Name____
Last First Middle

____
Address City State Zip Code

Date of Birth ______________________ Gender: % Male % Female
(MM / DD / YYYY)

Physician's Rx

Indications for Use

☑ **Please check all that apply** **Diagnosis Codes**

%	Ankle Pain & Support	729.50
%	Defective Circulation (lower extremity)	459.89
%	Joint Stiffness	719.57
%	Joint Swelling	719.07
%	Circulation (Peripheral Disorder)	785.59
%	Arthritis	716.97
%	Disuse Atrophy	728.20
%	Other (Must be specified)	______

SAMPLE

I am treating this patient under a comprehensive plan of care for diabetes mellitus / foot pain / arthritis. I, the undersigned certify that the above prescribed Ankle Foot Gauntlet is Medically Necessary for the patients' overall well being. In my expert opinion the Ankle Foot Gauntlet is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of this patients' condition and/or rehabilitation.

*____
(Physician Signature M.D. or D.O.) Date

* If a CRNP or PA signs Rx, to meet Insurance Guidelines an M.D. or D.O. wet ink or stamped Signature must accompany signature.*

Physician Information:

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Dr. Name UPIN

____
Address City State Zip Code

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Office Phone Office Fax