Phone Number: 423-631-0030
Fax Order To: 423-631-0052
Email Order To: info@medly-health.com

Bracing Physicians Order Form: Please include demographics and chart notes
(must include the need for the supplies ordered)

Rep: Anthony Crist **Facility Name:** _____

Patient Name: _____ Patient DOB: _____

Patient Phone: _____ Patient Email: _____

Insurance Policy: _____ ID #: _____

DIAGNOSIS (Please check all that apply)

- ☐ Chronic Ankle Instability
- ☐ Acute Ankle Sprain
- ☐ Subtalar Joint Sprain
- ☐ Syndesmosis Sprain
- ☐ Posterior Tibial Tendonitis
- ☐ Osteoarthritis
- ☐ Peroneal Tendonitis
- ☐ Foot/Ankle Fracture
- ☐ Achilles Tendonitis
- ☐ Moderate to Severe Ankle Sprain/Strain

MEDICAL NECESSITY (ALL FOUR MUST BE DOCUMENTED IN MEDICAL RECORDS)

- ☐ Must have weakness deformity of the ankle and foot; **AND**
- ☐ Requires Stabilization; **AND**
- ☐ Ambulatory; **AND**
- ☐ Have the potential to benefit functionally

FOOT BRACING

☐ Pneumatic Air Plastic (L4360)	☐ Short	☐ Tall	☐ Shoe Size: _____	☐ LT	☐ RT
☐ Pneumatic Fracture Walker (L4360)	☐ Short	☐ Tall	☐ Shoe Size: _____	☐ LT	☐ RT
☐ Full Plastic Shell Air Walker (L4361)	☐ Short	☐ Tall	☐ Shoe Size: _____	☐ LT	☐ RT
☐ Inline Foam Walker w/ Extra Long Wraps (L4361)	☐ Short	☐ Tall	☐ Shoe Size: _____	☐ LT	☐ RT
☐ Metal Uprights Walker (L4387)	☐ Short	☐ Tall	☐ Shoe Size: _____	☐ LT	☐ RT

ANKLE BRACING

☐ Sports Orthosis (L1902)	☐ Ankle CIR: _____"		☐ LT	☐ RT
☐ Sports Lace-Up Brace (L1902)	☐ Ankle CIR: _____"		☐ LT	☐ RT
☐ Functional Ankle Brace (L1906)	☐ Shoe Size: _____		☐ LT	☐ RT
☐ Rigid Medial & Lateral Uprights Brace (L1971)	☐ Shoe Size: _____		☐ LT	☐ RT
☐ Air/Gel Ankle Stirrup (L4350)	Height: ☐ 8.5"	☐ 10"	☐ LT	☐ RT
☐ Air Ankle Stirrup (L4350)	Height: ☐ 6"	☐ 8.5" ☐ 10"	☐ LT	☐ RT

PRESCRIBING PHYSICIAN INFORMATION

Provider Name _____ NPI _____

Address _____

Phone _____ Fax _____

Signature _____ Signature Date _____

(Stamped signature not accepted)