CUSTOM ORTHOTIC COVERAGE AND BENEFITS

PATIENT NAME: _____

PATIENT DOB: _____ PHONE: _____

INSURANCE PROVIDER: _____

INSURANCE ID #: _____

EFFECTIVE DATE: _____

DEDUCTIBLE = $_____ MET = $_____

OUT OF POCKET = $_____ MET = $_____

EXCLUSIONS: _____

INSURANCE COVERAGE FOR:

___ L 3000 - Custom Orthotics, UCB Berkeley Shell
___ L 3020 - Custom Orthotics, longitudinal support

DIAGNOSIS CODES:

___ M21.6X1 & M21.6X2 (Other acquired deformities of Right & Left Foot)
___ M19.071 & M19.072 (Primary osteoarthritis Right and Left Ankle & Foot)
___ M76.821 & M76.822 (Posterior tibial tendinitis Right & Left Leg)
___ M76.61 & M76.62 (Achilles tendonitis, Right & Left Leg)
___ M72.2 (Plantar fascial fibromatosis)
___ M20.11 & M20.12 (Hallux valgus (acquired), Right & Left Foot)
___ M20.21 & M20.22 (Hallux rigidus, Right & Left Foot)
___M20.41 & M 20.42 (Other hammer toe(s) (acquired), Right & Left Foot)
___E11.42 (Type 2 diabetes mellitus with diabetic polyneuropathy)
___E11.621 (Type 2 diabetes mellitus with foot ulcer)

REP'S NAME: _____

REF #: _____

DATE/TIME OF CALL: _____

DATE/TIME OF CASTING APPOINTMENT: _____

** Casting must be within 2 weeks of receiving insurance information **

** Deposit of $200.00 to be paid at the time of casting **

** Balance due at the time of dispense **

Cost of Custom Orthotics- $400.00

Please give completed form to front desk at time of casting appointment.