

The Foot Performance Center
3385 Brighton-Henrietta T.L. Rd.
Rochester, NY 14623
Ph: (585) 473-5950 Fax: 473-9596

Fiscal Order Form / Letter of Medical Necessity

Medicaid policies require that we have an original of this form.

We can accept a faxed copy of a Serialized official prescription with the following information; ICD-9 Code(s), Order and Goals. These requirements are for DMEPOS billing.

Date: _____

Patient's Name: _____

Date of Birth: _____ Insurance ID #: _____

(Please be as detailed as possible when filling out the following)

ICD-9 Code(s): _____

MEDICAID REQUIRES ICD-9 CODES.

Prescription: _____

Treatment Goals: _____

Is this treatment for a condition covered under the Physically Handicapped Children's Program? Yes _____ No _____

Is the condition being treated possibly disabling (causing an inability to engage in substantial or gainful activity which has lasted or can be suspected to last at least 12 months)? Yes _____ No _____

Is the condition being treated the result of an injury caused by an accident or crime? Check applicable:

Not Applicable _____ Accident-related injury, other _____ (Crime) assault victim _____
(Auto) no fault _____ (Auto) not no fault _____ (Auto) no fault benefits exhausted _____
(Work) worker's comp _____ (Work) not worker's comp _____
(Liability) actual _____ (Liability) potential _____

Physician Name: _____ Physician Signature: _____

Physician Address: _____ Phone # (____) _____

NPI # _____