

PLEASE RETURN TO \_\_\_\_\_

## LETTER OF MEDICAL NECESSITY AND PHYSICIAN ORDER FORM

*NOTE TO PHYSICIANS: YOUR PATIENT'S INSURANCE CARRIER REQUIRES COMPLETION OF THIS FORM (IN ADDITION TO YOUR PRESCRIPTION) IN ORDER TO CONSIDER THE CLAIM FOR THE MEDICAL DEVICE THAT YOU HAVE PRESCRIBED. PLEASE COMPLETE THIS FORM IN ITS' ENTIRETY TO HELP YOUR PATIENT AVOID A REJECTED CLAIM AND ADDITIONAL EXPENSES.*

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ ICD Code(s): \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_ ICD Code(s): \_\_\_\_\_

Prognosis: \_\_\_\_\_

Medical Device or Equipment Requested (i.e. shoes, shoe mods, orthoses, prostheses, other):  
\_\_\_\_\_

Frequency of Use:  Waking hours—all day  Waking hours—strenuous use  Sleeping  
Other: \_\_\_\_\_

Duration of Use:  <3 months  3-6 months  6-12 months  >12 months/active lifetime  
Other: \_\_\_\_\_

Expected Therapeutic Effect:  Reduce Pain  Stabilize joint  Maintain current functional status  
Other: \_\_\_\_\_

I certify that I have prescribed the items(s) above and it will be medically necessary for the care of my patient.

\_\_\_\_\_  
Physician Name (printed)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Address

\_\_\_\_\_  
Physician UPIN #

\_\_\_\_\_  
Physician Phone #

***PATIENTS: PLEASE CALL AHEAD FOR AN APPOINTMENT***  
**RICHEY & CO.**

**QUESTIONS: CALL TOLL FREE 1-8778-RICHEY • WWW.RICHEYCO.COM**

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**Original:** Keep at facility in client file

**Middle Copy:** Send to Office for billing

**Bottom Copy:** Give to Doctor