INSURANCE VERIFICATION

DATE & TIME OF CALL ____

PATIENT NAME____

PROCEDURE ______________________CUSTOM MOLDED FOOT ORTHOTICS_____________________

PROCEDURE CODE ___________L3030___________L3000___________RIGHT & LEFT FOOT__________

DIAGNOSIS____

DIAGNOSIS CODE (S) ____

DEDUCTIBLE $______________________ HOW MUCH MET? $__________________________________

COVERAGE____PERCENT

DO I NEED A LETTER OF MEDICAL NECESSITY? ____

DO I NEED A PRESCRIPTION? ____

IS PRE-CERTIFICATION REQUIRED? ____

AM I COVERED TO RECEIVE TWO PAIRS PER YEAR? _______________________________________

NAME OF PERSON CONTACTED____

REFERENCE # FOR PHONE CALL____

ORTHOTICS DEVICES MAY BE CONSIDERED “DURABLE MEDICAL EQUIPMENT”

I WANT TO RECEIVE CUSTOM MOLDED FOOT ORTHOTICS. SHOULD MY INSURANCE CARRIER DENY PAYMENT, OR STATE THAT ORTHOTICS ARE NOT A COVERED BENEFIT, I FULLY UNDERSTAND AND PERSONALLY AGREE TO ACCEPT RESPONSIBLITIY FOR PAYMENT OF THE CHARGES.

_____________________ ___________________________________

DATE RESPONSBILE SIGNATURE