Prior Approval Form for Lower Extremity Prosthetic Component L5781 or L5782

Refer to Subsection 5.3.10 of Clinical Coverage Policy 5B, Orthotics and Prosthetics, for more details

L5781: Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system

L5782: Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy-duty

Recipient name: _____ Date of Birth: _____

Medicaid number: _____

For prior approval of either of these prosthetic components, this form must be completed and signed by the referring physician and submitted with the certificate of medical necessity and supporting medical documentation.

Please check all of the following that apply to this recipient:

☐ 1. The recipient is classified as a functional Level 3 (K3), or above, ambulator.

☐ 2. The recipient is an experienced prosthetic user of 18 months or more.

☐ 3. The recipient has demonstrated volume fluctuation of at least the equivalent of 8 ply on a daily basis for at least 30 consecutive days while wearing a non-vacuum assisted socket.

☐ 4. The recipient's existing prosthesis, which requires replacement of the socket under the general coverage guidelines, is a vacuum assisted moisture evacuating socket design.

☐ 5. The recipient weighs more than 220 pounds (required for approval of L5782).

I certify that the information provided above is accurate and this component is medically necessary for this recipient.

Physician Signature: _____Date: _____

Physician Name Printed: _____

DMA-3350