

**Prior Approval Form for Lower Extremity Prosthetic
Component L5980**

Refer to Subsection 5.3.10 of [Clinical Coverage Policy 5B, Orthotics and Prosthetics](#), for more details
L5980: All lower extremity prostheses, flex-foot system

Recipient name: _____ Date of Birth: _____ Medicaid number: _____
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For prior approval of this prosthetic component, 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 requires a flex-foot system for specific functional activities. (List the specific activities and medical justification for each activity.)

_____ 2. The recipient's functional needs cannot be adequately met with any of the following prosthetic feet: L5976, L5979, or L5981. (Explain why each of these alternatives will not work.)

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

Physician Signature: _____ Date: _____

Physician Name Printed: _____