Prior Approval Form for Lower Extremity Prosthetic Component L5988

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

L5988: Addition to lower limb prosthesis, vertical shock reducing pylon feature

Recipient name: _____ Date of Birth: _____

Medicaid number: _____

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 the use of a vertical shock reducing component 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 an energy storage or dynamic response foot without the vertical shock component. (Explain why these other 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: _____