Prior Approval Form for Lower Extremity Prosthetic Component L5930

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

L5930: Addition, endoskeletal system, high activity knee control frame

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 is classified as a functional Level 4 (K4) ambulator.

☐ 2. An L5616 or other standard knee control frame or knee control frame system will not meet the functional needs of the recipient. (Provide detailed explanation)

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-3351