

FAX: Documentation Request

Fax to Name	Fax from Name	
Company	Company	
Phone	Phone	
Fax	Fax	
Patient	Date	No. Pages

We have received a referral to provide an **Ottobock Agilium Freestep** for the above patient. Please be advised that payment for an orthosis must be supported by information in the physician's contemporaneous medical records. Therefore we need the following information from your medical records in order to be in compliance and receive reimbursement. We appreciate your cooperation.

- History of Condition necessitating the Orthosis Diagnosis;** Affected Side; Clinical course; Therapeutic interventions and results; and Prognosis.
- Functional Limitations** ADLs and how impacted by deficit(s), Diagnoses causing these symptoms; other Comorbidities; and other Ambulatory assistance used (if any).
- Status/Condition of Current Orthosis**
- Past Experience with Orthoses/Braces, Mobility Aids, Medications, and other Failed Treatments**
- Recent Physical Exam specific to the condition** Include presence of deformity, swelling, tenderness, contracture, or spasticity; objective assessment of joint laxity/stability; range of motion; weight, height, weight loss/gain; etc.
- Imaging Reports specific to the condition**
- Recommendation for the new Orthosis/component(s)** Include the type of device (brand name not required), and your rationale for ordering it.

Please fax the signed and dated Medical Necessity documents to:

_____ at (_____) _____

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