CUSTOM ORTHOTIC COVERAGE AND BENEFITS

PATIENT NAME: _____ PATIENT DOB: _____

PHONE: _____ ALT CONTACT NUMBER: _____

INSURANCE PROVIDER: _____

INSURANCE ID #: _____ EFFECTIVE DATE: _____

DEDUCTIBLE = $_____ AMOUNT MET = $_____

OUT OF POCKET = $_____ AMOUNT MET = $_____

EXCLUSIONS (Can a Podiatrist/DPM dispense Custom orthotics?):

_____

INSURANCE COVERAGE FOR:

___ L 3000 - Custom Orthotics, UCB Berkeley Shell ___ L 3020 - Custom Orthotics, longitudinal support

DIAGNOSIS CODES:

___ M21.6X1 & M21.6X2 (Other acquired deformities of Right & Left Foot)

___ M19.071 & M19.072 (Primary osteoarthritis Right and Left Ankle & Foot)

___ M76.821 & M76.822 (Posterior tibial tendinitis Right & Left Leg)

___ M76.61 & M76.62 (Achilles tendonitis, Right & Left Leg)

___ M72.2 (Plantar fascial fibromatosis)

___ M20.11 & M20.12 (Hallux valgus (acquired), Right & Left Foot)

___ M20.21 & M20.22 (Hallux rigidus, Right & Left Foot)

___M20.41 & M 20.42 (Other hammer toe(s) (acquired), Right & Left Foot)

___E11.42 (Type 2 diabetes mellitus with diabetic polyneuropathy)

___E11.621 (Type 2 diabetes mellitus with foot ulcer)

REP'S NAME: _____REF #: _____

DATE: _____ TIME: _____

CASTING APPOINTMENT WITH MORE THAN JUST PODIATRY: _____

**** Casting must be within 2 weeks of receiving insurance information ****
**** Deposit of $200.00 to be paid at the time of casting ****
**** Balance due at the time of pick up ****
**** Cost of Custom Orthotics if not covered by insurance $400.00 per pair ****

PLEASE GIVE COMPLETED FORM TO THE FRONT DESK AT THE TIME OF CASTING APPOINTMENT