**Date:** [Insert Date]
**To:** [Insurance Company Name]
**Attention:** Medical Review/Prior Authorization Department

**Patient Name:** [Patient First and Last Name]
**Date of Birth:** [MM/DD/YYYY]
**Policy Number:** [Insert Policy ID]
**Group Number:** [Insert Group Number]
**Reference Number (if applicable):** [Insert Number]

**Subject: Letter of Medical Necessity for Custom Ankle-Foot Orthosis (AFO)**

To Whom It May Concern,

I am writing to formally request coverage for a custom-fabricated Ankle-Foot Orthosis (AFO) for the above-referenced patient. I have been treating this patient for [Duration of Treatment] regarding [Primary Diagnosis/Condition].

**Diagnosis and Clinical Findings:**
The patient presents with the following ICD-10 codes: [Insert ICD-10 Codes, e.g., M21.371, G82.20]. Clinical examination reveals: [List findings such as muscle weakness, foot drop, joint instability, or abnormal gait].

**Functional Limitations:**
Due to the conditions mentioned above, the patient experiences: [List limitations, e.g., frequent falls, inability to clear toe during swing phase, severe pain while walking, or high risk of skin breakdown].

**Necessity of Custom vs. Prefabricated Device:**
An off-the-shelf (prefabricated) AFO is contraindicated or inappropriate for this patient because: [Select reason: e.g., unique anatomical deformity, need for specific tri-planar control, severe spasticity, or history of skin ulcers from standard bracing]. A custom-molded device is required to provide the intimate fit necessary for stability and safety.

**Prescribed Equipment:**
[Insert specific HCPCS codes, e.g., L1960, L1970] - [Description of the specific custom AFO].

**Prognosis:**
The goal of this orthotic intervention is to improve gait efficiency, prevent further musculoskeletal deformity, and reduce the risk of injury. With the use of this custom AFO, the patient is expected to maintain or improve their current level of mobility and independence in activities of daily living.

I certify that the prescribed treatment is medically necessary and is the least costly alternative that meets the patient's specific clinical needs. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]
**[Physician Printed Name]**
**NPI Number:** [Insert NPI]
**Practice Name:** [Insert Practice Name]