Date: [Date]

To: [Insurance Company Name]
Attn: Prior Authorization Department
Fax/Address: [Fax Number or Mailing Address]

RE: Initial Prior Authorization Request for Custom Ankle Foot Orthosis (AFO)

Patient Information:
Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

Provider Information:
Ordering Physician: [Physician Name]
NPI: [Physician NPI]
Facility Name: [Facility/Clinic Name]
Contact Phone: [Phone Number]

Diagnosis/Clinical Information:
Primary Diagnosis: [ICD-10 Code and Description]
Secondary Diagnosis: [ICD-10 Code and Description]

Requested Items:
HCPCS Code: L1900-L1990 (Specify exact code, e.g., L1970 - Custom Molded Plastic AFO)
Addition Codes: [List applicable codes, e.g., L2820, L2275]

Medical Necessity Statement:
The patient presents with [Condition/Gait Abnormality, e.g., Foot Drop, Coronal Plane Instability]. A custom-fabricated AFO is medically necessary because:

- The patient has failed conservative treatment or prefabricated bracing due to [Reason: e.g., unique limb shape, severe deformity].
- The patient requires [Specific Support: e.g., mediolateral stability, dorsiflexion assist] to prevent falls and improve mobility.
- The patient is expected to be a functional ambulator with the use of this device.

Documentation Attached:
[ ] Clinical Evaluation/Physical Exam Notes
[ ] Gait Analysis Summary
[ ] Prescription/Detailed Written Order
[ ] Letter of Medical Necessity from Physician

Please contact our office at [Phone Number] if further information is required for the approval of this request.

Sincerely,

[Your Name/Signature]
[Title/Credential]