



1400049

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

## OUTSIDE FACILITY PROSTHETICS AND ORTHOTICS PRESCRIPTION

PATIENT NAME \_\_\_\_\_ UVA MRN \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

Rx

X \_\_\_\_\_  
SIGNATURE OF PRESCRIBER / NPI # PRINT NAME OF PRESCRIBER

.....

## LETTER OF MEDICAL NECESSITY

DIAGNOSIS: \_\_\_\_\_

PROGNOSIS: \_\_\_\_\_

SUPPLY/EQUIPMENT REQUESTED: \_\_\_\_\_

PRESENT PHYSICAL CONDITION: \_\_\_\_\_

DATE SUPPLY/EQUIPMENT NEEDED: \_\_\_\_\_

DURATION OF USE: \_\_\_\_\_

EXPECTED THERAPEUTIC EFFECT: \_\_\_\_\_

I CERTIFY THAT I HAVE PRESCRIBED THE ITEM(S) ABOVE AND IT WILL BE MEDICALLY NECESSARY FOR THE CARE OF MY PATIENT.

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Please Fax copy to 434-243-4665 and mail original to:

University of Virginia  
Prosthetics and Orthotics Department  
2280 Ivy Rd. Suite 1003  
Charlottesville, VA 22903  
434-243-4670 (P) 434-243-4665 (F)