HILL COUNTRY
Orthotics & Prosthetics

Orthotic Referral Requirements

1. **Referral.**
    - Type of device needed.
2. **Covered diagnosis.**
    - Not covered: PAIN diagnoses (the underlying cause of the pain must be specified).
    - Not covered: UNSPECIFIED diagnoses (site and side must be specified).
    - Covered examples: joint instability/weakness/improper gait due to underlying condition of specified side/site (i.e. instability due to osteoarthritis of the right knee).
3. **Progress notes.**
    - Documentation of covered diagnosis.
    - Type of device needed.
    - How the patient will benefit from the device.
        i. Example**:** Patient has instability due to osteoarthritis of the right knee and needs a knee orthosis to stabilize his/her gait when doing yardwork and grocery shopping.
    * *For replacements: reason for the replacement.*
        i. i.e. Stolen/irreparably damaged by a specific incident/patient physiological change.
        ii. Wear and tear is NOT covered.

AFTER Hill Country Evaluation:

4. **Detailed Prescription (Signature only).**
    - AFTER Hill Country Evaluation: we will create this form and send it for signature.
    - Other names for this form include: Detailed Written Order, Standard Written Order, CCP Form, Title XIX (depending on insurance).

HILL COUNTRY Orthotics & Prosthetics Orthotic Referral

CUSTOM & OFF-THE-SHELF BRACING

FAX ORDERS TO: 210-694-4581 • **CALL:** 210-614-8777 • **FIND US ON:** LeadingReach.com

1) Patient Information

Name | DOB | Phone Number 1 | Phone Number 2

Address Line 1 | City | State | ZIP | Sex

Primary Insurance Provider | Member ID # | Relationship to Subscriber

Secondary Insurance Provider | Member ID # | Relationship to Subscriber

2) Diagnosis

Diagnosis:

ICD-10(s)

Diagnosis Description(s)

Side:

☐ Bilateral ☐ Right ☐ Left ☐ N/A

Joint(s) Affected (if spinal, please specify the region)**:**

3) Referral

Length of Need:

☐ 6-12 Months ☐ 1-5 Years ☐ Lifetime

Please evaluate and treat for the following (select all that apply):

☐ Orthotic device (specify or describe): _____

☐ Custom orthotic device (specify or describe): _____

☐ Other (specify): _____

4) Signature of Referring Provider

The above procedures/devices are appropriate for this patient and are deemed medically necessary.

Signature | Name | Credentials | NPI | Date

PLEASE INCLUDE CLINICAL NOTES FROM A FACE-TO-FACE VISIT JUSTIFYING THE MEDICAL NECESSITY OF THE ITEMS PRESCRIBED.

Visit www.HillCountryOandP.com/OrthoticReferral for guidelines.