The Centers for Advanced Orthopaedics

The Orthopaedic Foot & Ankle Center

CUSTOM MADE ORTHOTICS

THIS FORM MUST BE FILLED OUT AND COMPLETED BEFORE YOUR APPOINTMENT. IF FORM IS NOT COMPLETE, YOUR APPOINTMENT WILL HAVE TO BE RESCHEDULED.

****Patients must arrive 15 mins prior to their scheduled appointment time. If you arrive late, you will be asked to reschedule.****

Patient's Name: _____

Information to ask your insurance carrier:

The billing code used for orthotics is **L3000 x2** (Standard orthotics) and **L3010 x2** (dress orthotics). Make sure you give your insurance representative these codes when checking your benefits. Your insurance will be billed for the left & right foot.

Are orthotics covered by my plan? YES NO

IF YES:

1. Does my insurance cover more than 1 pair a year? YES NO
   **If yes, how many per year? _____
2. At what percent are they covered? _____
3. Do I have a deductible? YES NO
   a. If yes, how much is my deductible per year? _____
   b. Has my deductible been met? YES NO
   c. If no, how much is remaining? _____
4. Is pre-authorization required? YES NO
   a. If yes, please call the office to inform us that authorization is needed at (703) 584-2040 ext. 1728.

Name of insurance: _____

Person you spoke with: _____ Date: _____

Financial Information: Information or benefits quoted above is not a guarantee of benefits. All claims are subject to deductible and out of pocket maximums. Please note that if you have a deductible, you're required to meet the full amount. This means that you will be billed the entire amount at the contracted rate until the deductible is met.

It is your responsibility to determine whether or not your insurance carrier covers prescription orthotics, and whether they cover them in full. Payment is required at the time of your visit. If your insurance requires pre-authorization, it is your responsibility to call the office before your appointment so that we can obtain authorization. You will not be seen for your appointment if authorization has not been obtained or if you come without this form completed. This applies to patients with primary and secondary insurance. **United Healthcare and Tricare required authorization.**

Signature of Patient/Guarantor: _____ Date: _____