Ankle & Foot of Edmonds

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Proliance SURGEONS

DJ Wardle, DPM Rex Nilson, DPM Eric Powell, DPM
7320 216th Street SW, Suite 320B Edmonds, WA 98026 Phone: 425.775.6996 Fax: 425.670.8905

# ORTHOTIC REQUEST FORM

Date _____

Patient's Name _____ DOB_____

Circle your Doctor's Name:

D.J. Wardle, DPM Rex Nilson, DPM Eric Powell, DPM

Address: _____ Phone: _____

_____ Weight: _____

_____ Age: _____

Insurance: _____ Shoe Size: _____

**FOR OFFICE USE ONLY**

Orthotic Request _____

_____

Insurance Benefit Check _____

_____

_____

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## ORTHOTIC COVERAGE

Orthotics are custom molded inserts intended to correct an abnormal or irregular walking pattern. Orthotics are not truly or solely "arch supports". They perform functions that make standing, walking, and running more comfortable and efficient by altering slightly the angles at which the foot strikes a walking or running surface.

Once your doctor has recommended orthotics for you, we recommend that you call your insurance company to verify your orthotic benefits. Insurance coverage varies from insurance to insurance and plan to plan. Please provide your insurance company with the orthotic billing code "L3000".

As a courtesy to you we will bill your insurance company for the orthotics. You need to understand that all fees are your responsibility. Any amount that is not covered by your insurance company will be considered your responsibility.

Some insurance companies do not offer orthotic coverage. For patients with no orthotic coverage, a payment plan is available. For information about payment plans, please talk to one of our front office staff.

**FOR MEDICARE PATIENTS**

Medicare does not cover orthotics; therefore, we do not bill them. Medicare patients need to pay for their orthotics in full at time of pick up; unless other payment arrangements have been made.

If for some reason your doctor authorizes a return, a refund will be given. The amount refunded will be the total amount that the patient paid for the orthotic appliance minus the lab-processing fee. The financial coordinator will verify the amount paid.

We thank you for letting us be of service to you.

_____ _____

Patient / Guardian Signature Date

_____ _____

Print name DOB