# Evaluation Form for Prosthetics, Prosthetic Components, and Replacements Request

*Instructions: Please complete all sections of this form to provide the necessary information for evaluating the requested prosthetic device, prosthetic components, or replacements. Each section is labeled to indicate whether it should be completed by the treating prescriber or the prosthetist. A submission is considered complete only when all required sections are filled out.*

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*Completed by Treating Prescriber*

## Patient Information

Patient Name: _____

Date of Birth: _____

Medicaid ID: _____

Treating Prescriber Name: _____

Treating Prescriber Office Phone or Email: _____

Treating Prescriber NPI Number: _____

Date of Submission**:** _____

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*Completed by Prosthetist*

## Requested Prosthetic Device, Component, or Replacement Information

Type of Request:

◯ New Prosthetic Device or Component

◯ Prosthetic or Component Replacement

Prosthetic Device or Component Requested: _____

HCPCS Code: _____

Manufacturer/Model (if applicable): _____

*Completed by Treating Prescriber*

## New Prosthetic Device/Component Information

(This section is ONLY for new prosthetic device/component requests)

### Activities of Daily Living (ADLs)

**Does the patient require the prosthesis/component to complete any of the following activities of daily living?**

◯ Yes ◯ No

**If yes, check all that apply:**

☐ Bathing and completing personal hygiene routines

☐ Dressing and changing clothes

☐ Eating

☐ Mobility, including: Transferring from a bed, chair, or other structure; moving, turning, and positioning the body while in bed or in a wheelchair; moving about indoors or outdoors

☐ Toileting, including: Bladder and bowel requirements; routines associated with the achievement or maintenance of continence; incontinence care

☐ Other: _____

Provide a detailed explanation of how the prosthesis/component will support these activities:

### Work, Home, or School Activities

**Does the patient require the prosthesis/component to perform essential tasks related to their work, home, or school activities?**

◯ Yes

◯ No

If yes, describe the tasks and how the prosthesis/component supports them:

*Completed by Treating Prescriber*

## Physical Activities

**Does the patient require the prosthesis/component to perform essential tasks related to physical or recreational activities?** (Check all that apply)

- ☐ Running
- ☐ Biking
- ☐ Swimming
- ☐ Strength training
- ☐ Other activities promoting whole-body health: _____

If yes, describe how the prosthesis/component will enable the patient to engage in these activities:

## Lower-Cost Alternatives

**Are there lower-cost alternatives that could meet the patient's needs for ADLs, work, home, school, or physical activities?**

- ◯ Yes
- ◯ No

If yes, describe the alternative solutions and explain why they are or are not suitable for the patient:

*Completed by Treating Prescriber*

## Prosthetic Device/Component Replacement Information

(This section is ONLY for prosthetic device/component replacement requests)

### Replacement Justification

**Reason for Replacement:** (Check all that apply)

- ☐ A change in the recipient's physiology that alters their physiological condition, resulting in the current prosthetic becoming suboptimally functional or ill-fitting
- ☐ Irreparable change in prosthesis/component condition
- ☐ Cost of repairs exceeds 60% of replacement cost

Please provide a detailed explanation for the reason(s) the prosthesis/component requires replacement:

**Confirmation:**

- ☐ I confirm the replacement is necessary due to one or more of the above reason(s).
- ☐ The need for replacement is not due to misuse.

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## Treating Prescriber Certification

I certify that the information provided in this form is accurate and based on my professional evaluation of the patient's medical needs.

**Signature:** _____

**Date:** _____

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## Prosthetist Certification

I certify the requested prosthesis/components are appropriate, technically suitable, and align with the prescriber's medical necessity determination.

**Name:** _____

**Signature:** _____

**Date:** _____