Insurance Verification for Functional Orthotics

This form is a supplement to the general services verification used by the practice. These specific questions are critical when verifying for coverage of functional orthotics.

Patient Name: _____ **Insured:** _____ **Insured's ID#:** _____

Insured's DOB: _____ **Policy#:** _____ **Employer:** _____

Patient's DOB: _____

Are custom-molded foot inserts (orthotics) covered when billed as code L3020? ○YES ○NO

IF YES	YES	NO
Do you have a specific Medical Review Policy for the use of this code? Where can I find it online? _____	○	○
Does the fee schedule have a maximum allowable (dollar limit) for L3020?	○	○
If yes, is this maximum amount per pair or per year?	○	○
Is this part of a separate Durable Medical Equipment (DME) benefit? What is the co-pay or co-insurance? _____	○	○
Are there certain diagnosis codes necessary for reimbursement of orthotics? If yes, where can I find them? _____	○	○
Is a Letter of Medical Necessity or is preauthorization needed?	○	○
Is a prescription from a physician required?	○	○
If yes, can the RX be from a Doctor of Chiropractic?	○	○
Do you cover Orthotics Management & Training, code 97760?	○	○
Do you cover Orthotics Management & Training, Subsequent, code 97763?	○	○
Do you cover therapeutic exercises, code 97110?	○	○
Do you cover extraspinal manipulation, code 98943?	○	○

IF NO (TIP: The functional orthotics themselves may not be specifically covered; ancillary services are usually covered in most plans.)	YES	NO
Where can I find in writing that orthotics are not covered in order to explain it to my patient?		
Do you cover Orthotics Management & Training, code 97760?	○	○
Do you cover Orthotics Management & Training, Subsequent, code 97763?	○	○
Do you cover therapeutic exercises, code 97110?	○	○
Do you cover extraspinal manipulation, code 98943?	○	○

Ask the following question if you are in network with the patient's plan:

If orthotics are not covered for this patient's diagnosis, can we accept payment directly from the patient with their acknowledgement to self-pay?

Name of Carrier for Claims Submission: _____

Address: _____
_____

Phone #: _____

Name of Rep: _____

Date and Time: _____

In/Out of Network: _____

NOTES