



CMN for Thermoskin AFG Stabilizer

Patient Name: _____ D.O.B: _____

Address: _____

City: _____ St: _____ Zip: _____ Phone: _____

AFG: R L BOTH SHOE SIZE _____

Indicate all applicable diagnosis

<input type="checkbox"/>	Ankle Pain & Support	729.5
<input type="checkbox"/>	Disuse atrophy	728.20
<input type="checkbox"/>	Neuropathy	337.1
<input type="checkbox"/>	Arthritis	716.97
<input type="checkbox"/>	Arthritis, Rheumatoid	714.00

<input type="checkbox"/>	Osteoarthritis, Degenerative	719.97
<input type="checkbox"/>	Pain, Joint	719.47
<input type="checkbox"/>	Joint Stiffness	719.57
<input type="checkbox"/>	Joint Swelling	719.07
<input type="checkbox"/>		

I certify that the above patient is under my medical care and the additional support offered with an ankle gauntlet is being prescribed to treat a weakness or deformity of the foot. The additional stabilization has the potential to benefit my patient functionally and is a medical necessity.

Prognosis: _____

Physician: _____ NPI: _____

Address: _____

City: _____ St: _____ Zip: _____ Phone: _____ Fax: _____

SIGNATURE: _____ Date: _____

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PLEASE FAX THIS FORM TO 1-877-699-6037