

**Prior Approval Form for Lower Extremity Prosthetic  
Component L5968**

Refer to Subsection 5.3.10 of [Clinical Coverage Policy 5B, Orthotics and Prosthetics](#), for more details  
L5968: Addition to lower limb prosthesis, multiaxial ankle with swing phase  
active dorsiflexion feature

Recipient name: _____ Date of Birth: _____ Medicaid number: _____
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For prior approval of this prosthetic component, this form must be completed and signed by the referring physician and submitted with the certificate of medical necessity and supporting medical documentation.

Please check all of the following that apply to this recipient:

- \_\_\_\_\_ 1. Standard multiaxial ankle-foot components will not meet the recipient's function needs.
  
- \_\_\_\_\_ 2. The recipient is not able to generate an adequate compensatory dorsiflexion response during swing phase with standard components.
  
- \_\_\_\_\_ 3. The recipient requires active swing phase dorsiflexion for specific functional activities. (List the specific activities and medical justification for each activity.)

I certify that the information provided above is accurate and this component is medically necessary for this recipient.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name Printed: \_\_\_\_\_