

**Prior Approval Form for Lower Extremity Prosthetic  
Component L5988**

Refer to Subsection 5.3.10 of [Clinical Coverage Policy 5B, Orthotics and Prosthetics](#), for more details

L5988: Addition to lower limb prosthesis, vertical shock reducing pylon feature

Recipient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicaid number: \_\_\_\_\_

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. The recipient requires the use of a vertical shock reducing component for specific functional activities. (List the specific activities and medical justification for each activity.)

\_\_\_\_\_ 2. The recipient's functional needs cannot be adequately met with an energy storage or dynamic response foot without the vertical shock component. (Explain why these other alternatives will not work.)

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

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

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