



**Prescription and Letter of Medical Necessity**  
**For Orthotic, Prosthetic and Pedorthic Services**

Date: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

PRESCRIPTION: SureStep De-rotation Strap

DIAGNOSIS /ICD-9: \_\_\_\_\_

EXPECTED LENGTH OF NEED: Indefinite

EFFECTIVE DATE OF PRESCRIPTION: \_\_\_\_\_

MEDICAL REASON FOR NEED: Medically necessary to reduce mild internal/external deviations of the lower extremity throughout the gait cycle through the use of dynamic torsion straps which allow freedom of movement but encourage correct positioning in the transverse plane.

\_\_\_\_\_  
(Physicians Signature)

\_\_\_\_\_  
(Physicians Phone #)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Physicians UPIN #)