



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

Date:

PATIENT'S NAME: _____

PRESCRIPTION: SureStep Advanced AFO

DIAGNOSIS /ICD-9: _____

EXPECTED LENGTH OF NEED: Indefinite

EFFECTIVE DATE OF PRESCRIPTION: _____

MEDICAL REASON FOR NEED: Medically necessary to provide support and stability to the foot and ankle complex, facilitate reduced ankle movement, improve standing / walking balance, decrease genu-recurvatum and reduce the risk of injury due to falls.

(Physicians Signature)

(Physicians Phone #)

(Date)

(Physicians UPIN #)