



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

Date:

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

PRESCRIPTION: SureStep PullOver 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, reduce undesired movement at the ankle joint, improve standing / walking balance, assist with clearance during swing phase, improve alignment throughout the lower extremities, and reduce the risk of injury due to falls.

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

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

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

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