

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

Date:

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

PRESCRIPTION: SureStep SMOs.

DIAGNOSIS / ICD-9: Severe Pronation (736.79), \_\_\_\_\_

EXPECTED LENGTH OF NEED: Indefinite

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

MEDICAL REASON FOR NEED: Medically necessary to provide support and stability for the foot and ankle complex, reduce the stress on the knee and hip joints, provide improved alignment throughout the lower extremities, encourage a more even, stable gait, decrease energy expenditure necessary for ambulation, encourage improved development of upright gross motor skills and decrease the risk of injury due to falls.

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

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

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

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