SureStep™

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 #)**