



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 #)