ALLIED OSI LABS AFO RECEIPT: Fall Protection Brace

Name of Practitioner: _____

Address of Practitioner: _____

City, State, Zip: _____

Patient's Name: _____

Patient's Address: _____

Medicare Number: _____

Date of Dispensing: _____

Brace Serial #: _____

Doctor _____ has dispensed:

- ☐ Custom Ankle Foot Orthosis HCPC Code L1940 for Left / Right (circle Left or Right or both)
- ☐ Lacer Molded to Patient Model: L2330
- ☐ Soft Interface: L2820

The above item(s) fits well, and is comfortable. I have received written instructions on how to use and care for them from Dr. _____ . The warranty period is 6 months for plastic components and 90 days for all soft materials (crepe, top-covers, Velcro limb support pads). I have read the posted Complaint Resolution policy and have been provided with a copy of the abbreviated 21 Medicare Supplier Standards. I understand that failure to properly care for these items will result in the warranty being void. This could result in my responsibility for future repair or replacement costs if my insurance policy will not cover such costs.

Patient's Signature _____ Date _____