



Dispensing Order

Please complete form below in its entirety and if possible, send **patient demographics** with insurance information. Please also include **physician chart notes** pertaining to the patient's orthotic and/or prosthetic needs.

Patient Information

Full Name: _____ DOB: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ City State ZIP Code

Phone: _____ Email: _____
FT CM LBS KG

Height: _____ Weight: _____

Treating Diagnoses/ ICD 10 Codes: _____

Device Prescribed

Affected Side: _____ Length of Need: _____ Prosthetic Functional Level: _____
RT LT BL K0 K1 K2 K3

Device Prescribed: _____

Physician Information and Certifying Signature

I certify that the above procedures and any repair and/or parts to maintain proper fit and function are appropriate for this patient and are deemed medically necessary.

Signature (No Stamps): _____ Date: _____

Physician Name: _____ NPI : _____

Address: _____
Street Address Phone Number

_____ City State ZIP Code