AFO RECEIPT CALIFORNIA

Name of Practitioner ____________________

Address of Practitioner ____________________

City, State, Zip ____________________

Patients 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) Foot with:

(check all that apply)

- ☐ Addition to Lower Extremity Molded Inner Boot: L2280
- ☐ Addition to Lower Extremity Varus/Valgus Control: L2275
- ☐ Orthotic Plate Accommodation: L3480
- ☐ Soft Interface: L2320

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 hardware components (hardware, plastic and metal 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 _____________________