AFO RECEIPT: CALIFORNIA

Practitioner Name: _____

Practitioner Address _____

City, State, Zip: _____

Patient Name: _____

Patient Address: _____

Medicare Number: _____

Date of Dispensing: _____

Brace Serial Number: _____

Doctor _____ has dispensed:
Custom Ankle Foot Orthosis - HCPC Code L1940 for (circle one) Left / Right Foot with check all that apply

- ☐ Solid AFO Shell: L1940
- ☐ Varus/Valgus Correction: L2275
- ☐ Lacer: 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 it 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 Complain 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 Signature: _____

Date: _____