

*American Limb & Orthopedic Company
Of Valparaiso*

**IT IS OUR POLICY PER NEW MEDICAL GUIDELINES TO
KEEP A PICTURE OF YOUR PROSTHETIC/ORTHOTIC
DEVICE ON FILE. THIS WILL BE KEPT IN YOUR FILE
ONLY TO BE USED FOR VERIFICATION OF DELIVERY IN
THE EVENT OF AN AUDIT BY MEDICARE OR YOUR
INSURANCE COMPANY.**

**YOUR AUTHORIZATION IS REQUESTED AT THIS TIME.
THANK YOU FOR YOUR ASSISTANCE.**

NAME: _____

DATE: _____

REFUSED: _____