Company Name: Home Heart Beats, LLC
9 Talcott Ct., Kendall Park, NJ 08824

Website: https://www.AFOassist.com

Phone: (732) 305-7689

Letter of Medical Necessity (LMN)

Patient Name:
Date of Birth:
Physician Name:
Physician NPI #:
Date:

Diagnosis & Medical Need

I am treating the above-named patient for the following medical condition(s):

☐ **Mobility impairment**

☐ **Neurological condition (e.g., stroke, cerebral palsy, multiple sclerosis)**

☐ **Orthopedic condition (e.g., ankle/foot deformity, muscle weakness, drop foot)**

☐ **Other: _____**

Medical Justification

The patient requires the use of an ankle foot orthosis (AFO) and corresponding footwear to maintain safe mobility and independence. Due to functional limitations in upper extremity mobility, the patient is unable to independently don (put on) the AFO and shoe without assistance.

To address the medical need, I am prescribing the use of the following adaptive device:

Product Name: *The Original* AFO Assist®

Product Type: Adaptive device designed to assist with donning an AFO and shoe

This device enables the patient to:

- Independently and safely don the AFO and shoe
- Maintain compliance with prescribed use of the AFO
- Reduce caregiver dependence and risk of falls
- Improve overall functional mobility and independence

Physician Certification

- I certify that this adaptive device is medically necessary for the treatment of my patient's diagnosed condition(s). This equipment should therefore be considered a qualified medical expense under IRS Section 213(d) making it eligible for purchase with HSA/FSA funds.

Physician Signature: _____

Date: _____