℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
AMBULATORY AIDES

Date of Last Provider Visit__________________

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
  713 Northway Dr. **Anchorage, AK 99508** **Phone: (907) 274-0770 Fax: (907) 274-0773** **NSC#: 1267160001**	**(_____) _______ - ___________ HIC#:________________** **Patient DOB:_____/_____/_____ Sex:_____ (M/F)**

An order was received on __________________ for the services/equipment provided to the above named patient. In order to properly bill for the services/equipment provided we require a revised detailed written order. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records. Prepared by:______________________

AMBULATORY AIDES:

Date of Service: ________________________________

Diagnosis and Code: ____________________________

Length of Need (# of months)______________1-99 (99=life)

Patient Height: __________ft. in.   Weight: _______ lbs.

Standard Equipment

- ❑ Cane, 250lb (E0100)
- ❑ Quad Cane, Small Base, 250lb (E0105)
- ❑ Quad Cane, Large Base, 250lb (E0105)
- ❑ Hemi Walker, 250lb (E0135)
- ❑ Forearm Crutches, 300lb (E0110)
- ❑ Underarm (Auxiliary) Crutches, 350lb (E0114)
- ❑ Walker, 300lb (E0135)
- ❑ Walker with Wheels, 300lb (E0143)
- ❑ Rollator, 300lb (Includes: Walker w/Wheels (E0143 & Walker Seat (E0156)
  Knee Walker 300lb (E0118)

Optional Equipment (Standard Equipment Only)

- ❑ Walker/Crutch Platform (E0154)
- ❑ 5" Wheels, Walker, Attachment (E0155)
- ❑ Tall Leg Extensions, Walker (E0158)
- ❑ Tall Wheel Extensions, Walker (E0158)

Bariatric Equipment

- ❑ Cane, HD, 700lb (E0100)
- ❑ Quad Cane, Small Base, HD, 700lb (E0105)
- ❑ Quad Cane, Large Base, HD, 700lb (E0105)
- ❑ Hemi Walker, HD, 650lb (E0135)
- ❑ Underarm (Auxiliary) Crutches, HD, 700lb (E0114)
- ❑ Walker with Wheels, HD, 500lb (E0149)
- ❑ Rollalator, HD (Includes: Walker with Wheels (E0149 and Walker Seat (E0156))

Is there a need for greater stability and security than provided by cane or crutches? ***(Walkers Only)***

❑ Y ❑ N

Is ambulation impaired?

❑ Y ❑ N

Is there a potential for ambulation?

❑ Y ❑ N

Updated 07-01-14

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living (MRADL) in the home?
   ❑ Y ❑ N

Reason for mobility limitation:

a. Prevents the patient from accomplishing the MRADL entirely,
   ❑ Y ❑ N

OR

b. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL.
   ❑ Y ❑ N

OR

c. Prevents the patient from completing the mobility-related activities of daily living within a reasonable time frame.
   ❑ Y ❑ N

2. Is the patient able to safely use the aide i.e. cane, walker or crutches?
   ❑ Y ❑ N
3. Can the functional mobility deficit be sufficiently resolved by use of a cane, walker or crutches?
   ❑ Y ❑ N

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

____

Provider's Signature   Date

____

Provider's Name

NPI: ________________ Telephone: _______________