℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
CANE & CRUTCHES

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **901 N Leatherleaf Loop** **Wasilla, AK 99654** **Phone: (907) 357-7882** **Fax: (907) 357-7883** **NSC#: 12671600033**	**(_____) _____ - _____ HIC#:_____** **Patient DOB:_____/_____/_____ Sex:_____ (M/F)**

We have been asked to provide the following equipment to the patient named above. 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.

AMBULATORY AIDS:

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=life)

Patient Height: _____ft. in. Weight: _____ lbs.

Standard Equipment

- ☐ Cane, 250lb max (E0100)
- ☐ Quad Cane, Small Base, 250lb max (E0105)
- ☐ Quad Cane, Large Base, 250lb max (E0105)
- ☐ Forearm Crutches, 500lb max (E0110)
- ☐ Underarm (Auxiliary) Crutches, 300lb max (E0114)

Optional Equipment (Standard Equipment Only)

- ☐ Crutch Platform (E0154)
- ☐ Ice Grips (A9999)

Bariatric Equipment

- ☐ Cane, HD, 700lb (E0100)
- ☐ Quad Cane, Small Base, HD, 500lb (E0105)
- ☐ Quad Cane, Large Base, HD, 500lb (E0105)
- ☐ Underarm (Auxiliary) Crutches, HD, 650lb (E0114)

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, or crutches?
   ☐ Y ☐ N
3. Can the functional mobility deficit be sufficiently resolved by use of a cane, 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: _____