℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
WALKER

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID#:**
PROCARE HOME MEDICAL **4215** Credit Union Drive Anchorage, **AK 99503** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**(_____) _____ - _____ Ins ID#:_____** **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

- ☐ Hemi Walker, 250lb max (E0135)
- ☐ Walker, 300lb max (E0135)
- ☐ Front Wheeled Walker, 300lb max (E0143)
- ☐ 4 Wheeled Walker with Seat, 300lb max (E0143/E0156)
- ☐ Knee Walker 300lb max (E0118)

Optional Equipment (Standard Equipment Only)

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

Bariatric Equipment

- ☐ Front Wheeled Walker, HD, 500lb max (E0149)
- ☐ 4 Wheeled Walker with Seat, HD 500lb max (E0149/E0156)

Is there a need for greater stability and security than provided by cane or crutches?

☐ Y ☐ N

Is ambulation impaired?

☐ Y ☐ N

Is there a potential for ambulation?

☐ Y ☐ N

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