℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
AMBULATORY AIDS

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **915 30th Avenue** **Fairbanks, AK 99701** **Phone: (907) 458-8912** **Fax: (907) 458-8914** **NSC#: 1267160002**	**(_____) _____ - _____ 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

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: _____