

**℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION  
WALKER**

Date of Last Provider Visit \_\_\_\_\_

Supplier Name, Address, Telephone & NSC#:



901 N Leather Leaf Loop

Wasilla AK 99654

Phone: (907) 357-7882

Fax: (907) 357-7883

NSC#: 1267160003

Patient Name, Address, Telephone & HIC#:

( ) - 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**

- Hemi Walker, 250lb max (E0135)
- Walker, 300lb max (E0135)
- Walker with Wheels, 300lb max (E0143)
- Rollator, 300lb max (Includes: Walker w/Wheels (E0143) Walker Seat (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**

- Walker with Wheels, HD, 500lb max (E0149)
- Rollator, HD 500lb max (Includes: Walker with Wheels (E0149) and Walker Seat (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: \_\_\_\_\_