# ℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
## AMBULATORY AIDES

**Date of Last Provider Visit**_____

| **Supplier Name, Address, Telephone & NSC#:** | **Patient Name, Address, Telephone & HIC#:** |
|---|---|
| PROCARE HOME MEDICAL<br>**4215 Credit Union Dr.**<br>**Anchorage, AK 99503**<br>**Phone: ( 907) 274-0770** **Fax: (907) 274-0773**<br>**NSC#: 1267160001** | **(_____) _____ - _____ HIC#:_____**<br>**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 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: _____