CANE & CRUTCHES STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID#:

Phone:_____ **Ins ID#:**_____

Patient DOB:_____ **Sex:** _____**(M/F)**

Refer to Cane & Crutches coverage criteria sheet for all required documentation.

Date of Last Visit: _____

AMBULATORY AIDS:

Diagnosis and Code: _____

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

Patient Height:_____in. Weight:_____ lbs.

Order Date: _____

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)

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)

Optional Equipment (Standard Equipment Only)

- ☐ Crutch Platform (E0153)
- ☐ Ice Grips (A9999)

MEDICAL NECESSITY INFORMATION: *Must also be supported in the medical records, if applicable*

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 reasonable 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 cane or crutches? ☐ Y ☐ N

3. Is the functional mobility deficit sufficiently resolved by use of a cane or crutch? ☐ 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:_____ NPI: _____

Provider's Name: _____ Telephone: _____