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.

AMBULATORY AIDS:

Date of Last Visit: _____ Order Date: _____

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=lifetime) Patient Height: _____ in Weight: _____ lbs.

Standard Equipment

- ☐ Cane, 700lb max (E0100)
- ☐ Quad Cane, 500lb max (E0105)
- ☐ Forearm Crutches, 500lb max (E0110)
- ☐ Underarm (Auxiliary) Crutches, 650lb max (E0114)

Optional Equipment (Standard Equipment Only)

- ☐ Crutch Platform Left Side (E0153)
- ☐ Crutch Platform Right Side (E0153)
- ☐ Ice Grips (A9999)

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: _____