

CANE & CRUTCHES STANDARD WRITTEN ORDER



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: _____

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)

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: _____